Envision the Possibilities: An Integrated Strategic Plan for Virginia's Mental Health, Mental Retardation, and Substance Abuse Services System

Department of Mental Health, Mental Retardation and Substance Abuse Services

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I. Executive Summary

This Integrated Strategic Plan (ISP) outlines a framework for transforming Virginia's publicly funded mental health, mental retardation, and substance abuse services system to:

- Fully implement self-determination, empowerment, recovery, resilience, and person-centered core values at all levels of the system through policy and practices that reflect the unique circumstances of each population group (see Appendix A for descriptions of these core values and their applicability to individuals with mental illnesses, mental retardation, and substance use disorders).
- Incorporate the principles of inclusion, participation, and partnerships into daily operations at all levels.
- Expand services and supports options needed to support individual and family choice, community integration, and independent living.
- Provide sufficient capacity to meet growing service needs so that individuals with mental illnesses, mental retardation, or substance use disorders, wherever they live in Virginia:
  - Receive the levels of services and supports they need,
  - When and where they need them,
  - In appropriate amounts, and
  - For appropriate durations.
- Promote the health of individuals receiving services, families, and communities.
- Increase opportunities for collaboration among state and community agencies.
- Align administrative, funding, and organizational processes to make it easier for individuals and families to obtain the services and supports they need.
- Monitor performance and measure outcomes to demonstrate that services and supports are appropriate and effective, promote services system improvement, and consistently report on the Commonwealth's implementation of the Integrated Strategic Plan.
- Provide stewardship and wise use of system resources, including funding, human resources, and capital infrastructure, to assure that services and supports are delivered in a manner that is efficient, cost-effective, and consistent with evidence-based and best practices.

Virginia's publicly funded mental health, mental retardation, and substance abuse services system is comprised of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) central office and state hospitals and training centers, a network of community services boards and a behavioral health authority (hereafter referred to as CSBs), local governments, private and public providers of a broad array of services licensed by the DMHMRSAS, and providers of other supports such as housing, job training, social services, and income assistance. The services system has a number of strengths that are essential for successful transformation. These include its:

- Long-standing willingness of state and local officials to support initiatives that enable Individuals with mental illnesses, mental retardation, or substance use disorders to live productively in their communities;
- Increasing individual and family activism;
- Dedicated and experienced workforce; and
- Successful partnerships that facilitate collaboration at the state, regional, and local levels.

However, the services system faces significant challenges that require immediate attention.

- Communities lack basic mental health, mental retardation, and substance abuse services capacity to address existing demand and anticipated population growth.
- State facilities are facing significant capital infrastructure needs and millions of dollars will be required to bring them up to required codes and therapeutic requirements.
- Increasing demands are being placed on the public services system and local hospital emergency rooms as private insurance benefits for behavioral healthcare continue to deteriorate, Medicaid and insurance reimbursement rates fail to cover even direct costs for covered services, and the number of uninsured Virginians increases.
- Private providers are closing their programs or are no longer serving individuals receiving publicly funded services because third party reimbursement rates do not cover the cost of providing their services.
- Some services are not as efficient and effective as they could be because of limitations imposed by current funding restrictions or categorical requirements.
- Federal budget deficits and competing national demands threaten the continued availability of services and supports that rely on federal funding.

The ISP is the product of a two-year strategic planning process that has involved hundreds of interested citizens. Seven Regional Strategic Planning Partnerships and five statewide Special Population Workgroups have examined emerging trends; assessed services system strengths, opportunities, challenges, and critical issues; explored opportunities for restructuring the current system; and developed recommendations for the ISP. Appendix B lists individuals who participated on the Regional Strategic Planning Partnerships and on the Child and Adolescent Services, Forensic Services, Geriatric Services, Mental Retardation Services, and Substance Abuse Services Workgroups. A compilation of services system strengths and opportunities, challenges, and emerging trends developed by these groups is provided in Appendix C. Recommendations of each Regional Strategic Planning Partnership and Special Population Workgroup are listed in Appendices D and E.

The ISP is intended to be strategic rather than comprehensive. Its purpose is to provide a blueprint and specific actions to implement the seven critical success factors that are essential building blocks for system transformation. Each critical success factor has specific implementation actions that propose policy, legislation, and administrative practice changes and state budget and capital initiatives.

II. Vision Statement

Our vision is of a “consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of

consumer participation in all aspects of community life including work, school, family and other meaningful relationships" (State Board Policy 1036 (SYS) 05-3).

III. Implementing the Vision: Description of a System of Recovery-Oriented and Person-Centered Services and Supports

Virginia's mental health, mental retardation, and substance abuse services system has changed dramatically over the last five years in concert with significant population growth and major changes in the state's health care industry. The Commonwealth has invested in services technologies and new medications that enable many individuals with acute and complex needs to remain close to their homes and natural supports. Some services that were once available only in state facilities are now provided in local hospitals or other community programs. The Discharge Assistance Program and the MR Home and Community-Based Waiver fund person-centered planning and individualized wrap-around services options that were not previously available to individuals and families. Partnerships among key services system players at all levels have transformed thinking about how services and supports should be funded, organized, and delivered.

The system is poised to put into practice the core values of self-determination, empowerment, recovery, and resilience, and the principles of inclusion and participation. This section describes how the transformed system would be structured and how the system would operate to meet its public services commitment.

A. Services Delivery System Structure: Key Roles and Responsibilities

At the state level, the DMHMRSAS, consistent with policy adopted by the State Mental Health, Mental Retardation and Substance Abuse Services Board, will provide leadership, vision, and strategic and policy direction for the services system. It will lead comprehensive and strategic planning for the services system and coordinate and integrate all initiatives that involve mental health, mental retardation, and substance abuse services or activities across state agencies and Secretariats and among all state government activities.

The DMHMRSAS will develop strong and sustained partnerships with CSBs, state agencies, individuals receiving services and supports and their families, local governments, and community providers to transform the services system to achieve the vision and service values articulated in the ISP. It will promote interagency collaboration at the state level and will serve as a catalyst for bringing together and influencing the capability of public and private providers of services and supports to respond to the needs and challenges experienced by Virginians with mental illnesses, mental retardation, or substance use disorders.

The DMHMRSAS will establish priorities and align funding and performance expectations to support the provision of available and accessible services and supports to individuals and families across the Commonwealth. It will champion and provide resources and expertise to implement services and supports that promote self-determination, empowerment, recovery, resilience, health, inclusion, and participation.

The DMHMRSAS will embrace a learning environment focused on continuous quality improvement, empowerment, and inclusion. This includes support for education, skill development, and training for a competent mental health, mental retardation, and substance abuse services professional, paraprofessional, and administrative and support workforce. The

DMHMRSAS also will assure that the human rights of individuals receiving services and supports are protected and public and private services adhere to standards of quality. The DMHMRSAS will promote best management and service coordination practices and will evaluate performance, manage utilization, and measure effectiveness.

The DMHMRSAS will assure the provision of high quality intensive services that are currently provided by state hospitals and training centers. Approaches for assuring and managing the provision of such services may differ to take advantage of regional opportunities; however, any structure for operating, managing, or coordinating these services will be consistent with the ISP's vision and service values.

At the local level, Virginia is fortunate to have created a structure in place that provides statewide coverage of publicly funded mental health, mental retardation, and substance abuse services. Because they establish CSBs, local governments will continue to play an important role in the publicly funded mental health, mental retardation, and substance abuse services system. In addition to providing financial resources, local governments may provide administrative services that are essential to the efficient and cost-effective operation of CSBs. Local governments also will provide or support a variety of services through other local agencies that are needed by individuals with mental illnesses, mental retardation, or substance use disorders.

This network of CSBs will continue to serve as the single point of entry into the publicly funded services system. As the single point of entry, CSBs will plan, coordinate, and monitor the provision of publicly funded services in their communities and will integrate and manage the utilization of these services provided by CSB and private sector providers, other local public agencies, and state hospitals and training centers. CSBs will partner with individuals and family members, DMHMRSAS, the state facilities, and community providers to transform the services system in support of quality initiatives and will promote interagency collaboration at the local level.

CSBs will provide or contract for a comprehensive array of mental health, mental retardation, and substance abuse services and supports that are designed to implement principles of self-determination, empowerment, recovery, and resilience. CSBs will assess the individualized services and supports needs of persons with mental illnesses, mental retardation, or substance use disorders who are seeking care from the services system and will work to keep individuals in the least restrictive environment and as close to home and to their natural supports as possible. They will perform case management and care coordination functions. This includes coordination of the care that individuals receive, including care provided in state hospitals and training centers or though multiple CSB arrangements, and will provide the focal point for local services accountability and individual and family involvement.

In addition to services provided by or through the CSBs, the publicly funded services system will encompass a broad array of varied services and supports provided by local hospitals, peer-run and peer-to-peer programs, schools, and private providers. These providers will offer, as an essential part of the services system, options and alternative choices for individuals with mental illnesses, mental retardation, or substance use disorders.

Other state and local agencies will provide or fund a range of supports, including health care, vocational training, social services, and housing assistance, that respond to the needs of individuals with mental illnesses, mental retardation, and substance use disorders. Through interagency coordination and cooperation at state and local levels, individuals and their families will have single entry access to needed services and supports. Adults and children who require

multiple agency involvement and their families will receive seamless services delivery across agencies.

Virginia's academic medical centers will provide expertise in evidence-based psychiatry and specialty care, develop and test new models of care, and conduct applied and basic research that strengthens systems and improves care. These centers and other university and community college programs will train the services system's existing and emerging workforce to increase the availability of skilled and knowledgeable professional, paraprofessional, administrative/support staff. In addition, the academic medical centers may provide inpatient, transitional, and outpatient psychiatric and addiction services to adults and children.

B. Virginia's Public Service Commitment

State and local government have a collective responsibility for assuring the provision of a "safety net" of appropriate services and supports in safe and suitable settings for individuals with mental illnesses, mental retardation, and/or substance use disorders who are in crisis or who have severe or complex conditions, or both, and cannot otherwise access needed services and supports because of their level of disability, their inability to care for themselves, or their need for a structured or secure environment.

Implementation of this "safety net" would be flexible and would draw on the collaborative efforts of DMHMRSAS, CSBs, and other healthcare providers who care for individuals who are uninsured, have serious mental illnesses, mental retardation, or substance use disorders, or both. This "safety net" would adapt according to the needs of each person and the availability of services and supports that address those needs. For example, "safety net" crisis stabilization services would be provided as close to an individual's home and natural supports as possible. Such services might include intensive in-home assistance offered by a MR/MI behavioral intervention team to stabilize the crisis, a brief stay in a local or regional crisis intervention program for persons with mental illnesses or co-occurring disorders, or admission to a community hospital for acute psychiatric or detoxification services. However, when these services are not available or appropriate or more specialized or intensive services are needed, the state would continue to assure the provision of such services. State training centers would provide a safety net for individuals with the most medically complex or behaviorally challenging service needs.

The services system would have a wide "front door" for screening and assessing individuals with mental illnesses, mental retardation, or substance use disorders who seek publicly funded services or supports. Referrals to this "front door" would come directly to the CSB or through referrals to CSBs from local hospital emergency rooms or other local agencies. All individuals and families seeking services and supports would be provided timely and thorough initial screening and state-of-the-art assessments provided by well-qualified and highly trained staff. Specialized assessments would be provided to individuals such as those with co-occurring disorders and gero-psychiatric needs. Assessment results would determine the types, levels, and amounts of needed services and supports depending upon the complexity of the individual's condition or his level of functioning. Services and supports options would reflect the core values of self-determination, recovery, resilience, and person-centered planning. Appendix F describes two potential models for aligning services and supports interventions with acuity and complexity and level of functioning.

Access to and continuation in the most intensive services would be rigorously screened and continuously reviewed to assure services are provided in the most integrated and least intrusive setting appropriate to the acuity and complexity of the individual's condition or his level of

functioning. Referrals to emergency and crisis services would be immediate. Referrals to non-emergency services and supports provided by the CSBs, peer-run organizations, local agencies, or other providers would be within a reasonable period of time based on individual need. Services utilization, including hospitalization, would be managed by the CSBs in collaboration with other providers, as appropriate, for the period suitable to the needs of the individual.

C. Services and Supports:

1. Goal

Adults and children with mental illnesses, mental retardation, or substance use disorders are members of the community in which they live and should enjoy the same opportunities for quality of life. The overarching goal of the services system is to provide or assist individuals in obtaining services and supports based on informed choice that would enable them to:

- Attain their highest achievable level of health and wellness;
- Live as independently as possible, with children living with their families;
- Engage in meaningful activities, including school attendance or work in jobs that they have chosen; and
- Participate in community, social, recreational, and educational activities.

2. Values

The design and operation of services and supports would be based upon the following values:

- Services and supports are person-centered. Individuals receiving services and family members have access to information, are involved in service planning, and have decision-making power over the types of services and supports they need and use. The specific needs of each individual are at the center of service planning and care coordination.
- The services system is designed to intervene early to minimize crises through early screening and assessment, appropriate interventions that keep individuals receiving services connected to their families and natural supports, and seamless access to services.
- Services and supports are available and delivered as close as possible to the individual's home community in the least restrictive setting possible, are culturally and age sensitive and appropriate, and are fully integrated and coordinated with other community services.
- Adults and children requiring services and supports from multiple agencies are provided care that is coordinated across agencies.
- Services and supports are flexible, allow for the greatest amount of individual choice possible, and provide an array of acceptable options to meet a range of individual needs.
- A consistent minimum level of services and supports is available across the system, with timely access to needed services.
- Prevention, early intervention, and family support services are critical components of the services system.
- Services are universally and equally accessible regardless of the individual's payment source.
- Services are of the highest possible quality and are based upon best and promising practices where such practices exist.

- Services are provided in an efficient and cost-effective manner to enhance service quality and continuity of care and to take advantage of technologies that provide appropriate access to properly protected information.
- Emphasis is placed on continuous quality improvement at the provider and system levels, with performance and outcome measures focused on self-determination, empowerment, recovery, resilience, and community integration.
- Integrated and flexible public funding of mental health, mental retardation, and substance abuse services promotes person-centered and recovery-oriented service and supports.
- Public funding is adequate to meet individual needs and includes cost inflators to sustain capacity and address the total costs of service delivery.
- The services system is committed to state facility and community workforce training, retraining, development, retention, and expansion to needed staffing levels.

3. Availability of Services and Supports

a. Access to Emergency Services

Every locality would have the capacity to provide, either locally or through regional arrangement, crisis access and response 24 hours per day/seven days a week. The following crisis access and response services would be available:

- Locally provided emergency services;
- In-home assistance to stabilize a crisis;
- Non-hospital crisis stabilization and detoxification; and
- Acute stabilization in local hospitals.

b. Access to a Core Array of Non-Emergency Services and Supports

Following assessment, services and supports choices would be identified for each individual. These choices would be flexible and provided as close to the individual's home and natural supports as possible. Regardless of where an individual lives in the Commonwealth, individuals and their families would have access to a broad array of services and supports that promote independence and enable individuals to live in their own homes or natural environments wherever possible, and when not possible, with other family members.

Recovery and resilience-oriented and person-centered services, training, and supports provided by and for individuals and families would be developed and expanded, including:

- Peer-run programs,
- Individual and family education and support,
- Family resource centers,
- Individual wellness recovery planning, and
- Peer-to-peer drop-in centers.

At the local level, recovery and resilience-oriented and person-centered services and supports would include the following core array of services provided by CSBs directly or through contracts with other community providers.

- Prevention and early intervention services,
- Infant and toddler intervention,
- Respite care,
- In-home services including intensive in-home therapy by licensed clinicians,
- Care coordination and case management,
- Medication and medication education services,
- Outpatient treatment using best and promising practices provided by specially trained clinicians,
- Integrated treatment for individuals with co-occurring MI/SA, MI/MR, and MR/SA diagnoses,
- Supported employment and vocational training,
- Rehabilitation and day support services,
- Day treatment provided in schools or clinics,
- Supervised and supportive residential services, and
- Intensive community treatment, training, and transitional services.

In addition, a system of care for children and adolescents would be available. This system of care would include cross-agency planning and coordination at the local level with child-serving agencies and the Comprehensive Services Act teams; with family involvement; respite care services; family supports; behavioral health support for schools, court services, health departments, and social services; and early intervention services through local schools, behavioral health, and other health care clinics.

While it is preferable in most instances to provide services and supports in an individual's home community, there may be situations where needed services are beyond the capacity of most localities to provide. These would be provided at the regional level through specialized teams, regional programs, or utilization of emerging technologies such as teletherapy or teleconsultation. They include, when necessary:

- Regional MR/MI behavioral consultation teams;
- Regional MI/SA consultation teams;
- Expert consultation teams for nursing homes and assisted living facilities; and
- Specialty clinical services (e.g., extensive assessments for medical and psychiatric needs, child and family therapy, and medical and dental supports).

Some specialty services would be available at the statewide or regional level.

- Intermediate treatment and rehabilitation and intensive treatment for individuals with severe or complex conditions, or both, requiring care in state mental health facilities;
- Intensive short-term acute inpatient crisis intervention, stabilization, and treatment for children and adolescents with high acuity or high complexity behavioral health conditions, or both;
- Intensive medical (to include skilled nursing), behavioral, or other specialized supervision and therapeutic interventions provided in Intensive Support Centers ISCs) or Intensive Support Homes (ISHs) – see the MR Services and Supports Options by Level of Care Model described in Appendix F;

- Secure forensic and not guilty by reason of insanity (NGRI) services; and
- Behavioral rehabilitation services for sexually violent predators.

D. Integrated Funding

To the extent possible, funding should follow the individual and not a specific provider or service. Integrated funding, with cost of living escalators, would reduce the complexity of funding and provide the flexibility needed to create choices among the core array of services and supports that promote self-determination and person-centered planning, empowerment, recovery, and resilience for individuals receiving services.

IV. Critical Success Factors for Strategic Action

Seven critical success factors described below are required to transform the current services system's "crisis-response" orientation to one that provides incentives and rewards for implementing the vision of a recovery and resilience-oriented and person-centered system of services and supports. Successful achievement of these critical success factors will require the support and collective ownership of all system stakeholders.

A. Virginia successfully implements a recovery and resilience-oriented and person centered system of services and supports.

This critical success factor envisions the alignment of services system policies, regulatory requirements, funding incentives, and services and supports arrangements with the core values of self-determination, empowerment, recovery, and resilience at the state and local levels. Individuals receiving services and supports are empowered and supported in making decisions about their lives and their services. Providers recognize that these core values can be strengthened through respect for age, gender, spiritual, language and other cultural considerations.

B. Publicly funded services and supports that meet growing mental health, mental retardation, and substance abuse services needs are available and accessible across the Commonwealth.

This critical success factor envisions a core array of recovery and resilience-oriented and person-centered services and supports that is available to individuals regardless of where they live. Natural support systems are identified and strengthened wherever possible and emphasis is placed on prevention and early interventions to avoid future crises.

C. Funding incentives and practices support and sustain quality care focused on individuals receiving services and supports, promote innovation, and assure efficiency and cost-effectiveness.

This critical success factor envisions adequate amounts of stable state and local funding that can be used flexibly to meet the needs of individuals and their families. The services system takes full advantage of federal funding opportunities, including Medicaid, to implement recovery and resilience-oriented and person-centered services.

D. State facility and community infrastructure and technology efficiently and appropriately meets the needs of individuals receiving services and supports.

This critical success factor envisions significant improvement in the adequacy and appropriateness of state and community capital infrastructure. The services system takes advantage of technologies to improve care coordination and continuity.

E. A competent and well-trained mental health, mental retardation, and substance abuse services system workforce provides needed services and supports.

This critical success factor envisions a workforce with leadership, technical, and collaboration (team) skills and expertise. The services system recruits and retains sufficient numbers of professional, paraprofessional, and direct care staff and provides opportunities for individuals receiving services and supports to offer peer-support and self-directed services and operate peer-run programs, services, and businesses.

F. Effective service delivery and utilization management assures that individuals and their families receive services and supports that are appropriate to their needs.

This critical success factor envisions the implementation of consistent management practices that focus on and support the delivery of recovery-oriented and person-centered services and supports. Highly qualified and trained professionals perform initial screenings and assessments of service needs. Service areas are configured to assure quick access to services and supports that are easy to navigate and user-friendly. Regional structures support partnership planning, collaboration, and management of services utilization.

G. Mental health, mental retardation, and substance abuse services and supports meet the highest standards of quality and accountability.

This critical success factor envisions statewide implementation of clinical and management practices that reflect best and promising practices. The services system promotes and supports organizational learning, services improvement, and accountability. Providers demonstrate quality, efficiency, and cost-effectiveness through clearly defined performance expectations and individual outcomes that are measured and monitored with stakeholders through an open process. Positive outcomes rewarded.

V. Action Plans for Each Critical Success Factor

A. Virginia successfully implements a recovery and resilience-oriented and person-centered system of services and supports.

Services System Expectations:

- State and local government policy-makers and administrators, individuals receiving services and supports, family members, and providers understand, believe in, and have the necessary competencies and skills to employ recovery, resilience, and person-centered practices and incorporate the principles of inclusion into policy, funding, and operational decision making.
- Programs and services structures promote recovery, resilience, and person-centered principles and practices in areas of
  - ☑ Prevention and health promotion,
  - ☑ Consumer involvement,
  - ☑ Access and engagement,
  - ☑ Continuity of care,

- ☑ Individualized recovery and person-centered planning,
- ☑ Recovery support staff and personal assistance,
- ☑ Community inclusion,
- ☑ Housing and work,
- ☑ Evidence-based, best, and promising practices,
- ☑ Cultural competency, and
- ☑ Quality and performance. (*Implementing a Statewide Recovery-Oriented System of Care: From Concept to Reality*, Presentation by Thomas A. Kirk, Jr., Arthur C. Evans Jr., and Wayne F. Dailey, NASMHPD Research Institute, February 2005)

- ➢ Funding incentives and administrative policies and requirements are aligned in support of recovery, resilience, person-centered planning, and community integration.
- ➢ The culture of the services system is based on the vision and service values described in the ISP, with informed choice guiding individual and family decisions regarding services and supports.

Implementation Actions:

1. *Create awareness and understanding of recovery and resilience-oriented and person-centered principles and practices.*

   a. Implement an educational campaign to increase awareness of key policymakers, state and local government officials, individuals and family members, public and private providers, and the general public. (2006-2008 biennium)

   b. Implement a variety of training opportunities designed to increase the knowledge and skills of staff at all levels of state facilities and community provider organizations in implementing recovery, resilience, and person-centered principles and practices. (2006-2008 biennium)

   c. Support peer-to-provider training and other learning opportunities for staff of the Department's central office, state facilities, and licensed public and private providers on how they might align their organizational cultures with the vision and services values. (Ongoing)

   d. Publicize the commitment of services system leaders to recovery and resilience-oriented and person-centered principles and practices. (Ongoing)

2. *Transform current services system policies and regulations, incentives, service structures, and practices to support implementation a recovery and resilience-oriented, and person-centered system of care.*

   a. Adopt a state policy on self-determination, empowerment, recovery and resilience. (FY 2006)

   b. Provide DMHMRSAS central office leadership required to implement ISP strategic actions and other services system transformation activities. (Ongoing)

   c. Increase the number of participants in individual and family education, wellness and recovery planning, empowerment training, and recovery-based peer-to-peer training programs. (2006-2008 biennium)

   d. Incorporate recovery and resilience-oriented and person-centered principles in the revision of the DMHMRSAS human rights regulations (FY 2006) and in the licensing regulations (FY 2007).

e. Involve DMHMRSAS central office staff, state facilities, CSBs, and other public and private providers in an examination of how current practices for managing risk affect self-determination, empowerment, recovery, and resilience. (FY 2006)

f. Launch a demonstration project to implement recovery and resilience-oriented and person-centered principles in one or more regional or sub-regional networks of care. (FY 2006)

g. Support the efforts of state hospitals and training centers to develop and disseminate new knowledge on how to implement recovery, resilience, and self-determination principles in a state facility setting. (FY 2006)

B. Publicly funded services and supports that meet growing mental health, mental retardation, and substance abuse services needs are available and accessible across Virginia.

Services System Expectations:

- Community service capacity is sustained and addresses existing demand for services.
- A core array of services and supports is available and accessible in localities across the Commonwealth.
- Funding levels are sufficient to provide a core array of mental health, mental retardation, and substance abuse services and supports across the Commonwealth that are sustained with cost inflators.
- Providers assure that individuals receiving services and supports and family members have the opportunity to communicate their needs and to make choices about how these needs are met.

Implementation Actions:

1. *Standardize emergency (crisis access) and stabilization, case management, and rehabilitation services to recovery-oriented and person-centered principles and best practices.*

2. *Establish services and supports that that minimize crises, reduce reliance on the most intensive levels of care, and promote independent living and individual and family choice.*

   a. Address critical community services and supports deficits and emerging needs through the DPB agency strategic planning and biennial budget development process. (2006-2008 biennium)

   b. Develop peer and family networks and peer-run services and supports. (2006-2008 biennium)

   c. Continue to establish intensive community services capacity that provides alternatives to and timely discharge from psychiatric hospitalization and promotes community integration. (2006-2008 biennium)

   d. Complete an assessment of the extent to which the core array of services and supports envisioned in the ISP is available and accessible in each CSB service area. (2007)

   e. Support regional and CSB efforts, as necessary to develop and align their existing services and supports with the core array of services and supports. (Ongoing)

   f. Implement additional systems of care projects to serve children and adolescents. (2006-2008 biennium)

g. Initiate implementation of the "Suicide Prevention Across the Lifespan Plan for the Commonwealth of Virginia" as described in the Plan. (2006-2008 biennium)

h. Establish, as an integral part of the implementation of the MR Services and Supports Model, intensive community capacity and behavioral consultation services that provide alternatives to training centers and promote community integration. (2006-2008 biennium)

i. Increase the number of individuals receiving MR Home and Community-based Waiver and family supports. (2006-2008 biennium)

j. Develop innovative ways to serve children and adults who have mental retardation, including those who are or are not eligible for the MR Waiver. (2006-2008 biennium)

C. Funding incentives and practices support and sustain quality care focused on individuals receiving services and supports, promote innovation, and assure efficiency and cost-effectiveness.

Services System Expectations:

- Access to mental health, mental retardation, substance abuse, and medical services is provided through funding streams that lead to the integration of care and alignment with recovery and resilience-oriented and person-centered principles.
- Funding allocations include incentives for efficient and cost-effective services that and consistent with evidence-based, best, and promising practices.

Implementation Actions:

1. *Implement recovery and resilience practices in Medicaid mental health, mental retardation, and substance abuse service policies and expand opportunities for individual and family participation in individual-directed services.*

   a. Work with the Department of Medical Assistance Services, CSBs, and the Virginia Hospital and Healthcare Association to document the impact of existing reimbursement rates on the ability of local hospitals to provide psychiatric services. (2006-2008 biennium)

   b. Work with the Department of Medical Assistance Services, CSBs, and the JLARC to document the impact of existing reimbursement rates on the ability of private and public providers to provide MR waiver services. (2006-2008 biennium)

   c. Incorporate recovery, resilience, and person-centered practices into targeted case management and state plan option service clarifications. (2006-2008 biennium)

   d. Explore opportunities to revise the MR Waiver to increase flexibility and address issues with the current waiver (e.g., general supervision). (2006-2008 biennium)

   e. Maximize opportunities within the State Medicaid Assistance Plan to provide Medicaid-coverage for SA services for persons with co-occurring MI/SA. (2006-2008 biennium)

   f. Maximize opportunities within the State Medicaid Assistance Plan to provide Medicaid-coverage for peer support providers and peer drop-in programs. (2006-2008 biennium)

2. *Establish funding mechanisms that allow flexibility in creating individualized recovery-oriented and person-centered services plans that are based on informed choice and respond to the needs of individuals.*

a. Promote the sharing of methods to maximize revenues among services providers. (Ongoing)

b. Assess the extent to which federal and state requirements allow or prohibit blending or braiding of funding streams and whether waivers might be sought. (FY 2006)

c. Assess the feasibility of implementing self-directed care models in Virginia. (FY 2006)

d. Develop policies and procedures for integrating existing DMHMRSAS funding streams in ways that support individualized and flexible delivery of services and supports. (FY 2006)

D. State facility and community infrastructure and technology efficiently and appropriately meets the needs of individuals receiving services and supports.

Services System Expectations:

- State facility responsibilities within the transformed system of care are clearly defined and capacities reflect investment in community services.
- State facility and community buildings are safe, adequate, and appropriate to the needs of individuals.
- State training centers are replaced with Intensive Support Centers (ISCs) and Intensive Support Homes (ISHs), as envisioned in the MR Services and Supports Options by Level of Care Model.
- Technologies are implemented to improve coordination and continuity of *service* delivery, support the development of promising practices, and increase access to services in underserved areas.

Implementation Actions:

1. *Implement a statewide master capital plan for the renovation or replacement of state mental health and mental retardation facilities and the improvement of community infrastructure.*

   a. Make critical state facility repairs that are necessary to maintain CMS certification and meet JACHO standards. (2006-2008 biennium)

   b. Implement the MR Services and Supports Options by Level of Care Model. (Beginning in the 2006-2008 biennium)

   c. Implement new state mental health facility designs that more appropriately and efficiently respond to the needs of individuals receiving services. (Beginning in the 2006-2008 biennium)

2. *Support community capital infrastructure and capacity development by CSBs.* (2006-2008 biennium)

   a. Provide funds, as part of the transformation initiative, to support the purchase, renovation, or construction of a wide array of transitional housing and other community-based diversion programs; provide one-time program start-up costs; implement evidence-based and best practices and retool of existing services; and leverage other public and private infrastructure and capacity development resources. (2006-2008 biennium)

3. *Develop and manage information efficiently in an environment that is responsive to the needs of users and protects identifiable individual health information.* (2006-2008 biennium)

a. Implement a pharmacy information system for state facility pharmacies and the Community Resource Pharmacy. (2006-2008 biennium)

b. Design and develop a set of information technology applications to support transformation implementation activities and address outcome measurement requirements for mental health, mental retardation, and substance abuse services. (2006-2008 biennium)

c. Participate with the Secretary of Health and Human Resources and other state agencies in exploring requirements, to include advance directives and wellness recovery plans, for an electronic health record. (FY 2006)

d. Participate with the Department of Health in a pilot program to connect electronic health records across clinic sites, including CSBs, in one region and evaluate the usefulness of an automated records system. (FY 2006)

E. A competent and well-trained mental health, mental retardation, and substance abuse services system workforce provides needed services and supports.

Services System Expectations:

- Sufficient numbers of professional, paraprofessional, and administrative support staff provide individually focused services and supports.
- The services system workforce has appropriate skills and expertise to deliver best and promising practices.
- Mechanisms are in place to recognize and reward exemplary staff across the services system.
- Providers are skilled in meeting the needs of the most challenging individuals, including those with co-occurring disorders and gero-psychiatric populations.

Implementation Actions:

1. *Establish public-academic partnerships with Virginia universities, colleges, community colleges, and other learning organizations to expand the pipeline and skill levels of hard-to-fill professional and direct care positions and to increase their knowledge of recovery, resilience, and person-centered concepts and practices.*

    a. Provide scholarships and other incentives to increase the number of students entering training and academic programs targeted to difficult-to-fill professional and direct care positions. (2006-2008 biennium)

    b. Promote opportunities for distance learning. (2006-2008 biennium)

    c. Explore potential public-academic partnerships to support on-site-training of graduate, undergraduate, and medical students at state facilities and CSBs. (2006-2008 biennium)

2. *Increase the skills and productivity of professional, paraprofessional, and administrative support staff and their knowledge of recovery, resilience, and person-centered concepts and practices through distance learning, regional and statewide training programs, conferences, and other learning opportunities.*

    a. Implement training and cross-training programs designed to develop provider skills necessary to meet the needs individuals with co-occurring disorders and the gero-psychiatric population. (2006-2008 biennium)

b. Promote cross-training of nursing home staff to address the needs of individuals who are at risk of institutional placement due to psychiatric or behavioral needs. (2006-2008 biennium)

c. Establish one or more regional community support centers at state mental hospitals to provides guidance to community providers on serving individuals who are at risk for aggressive behavior. (2008-2010 biennium)

d. Promote the implementation of the College of Direct Supports statewide. (Ongoing)

3. *Remove barriers, create opportunities, and provide training and educational opportunities for individuals receiving services and supports to develop skills necessary to offer peer-support and self-directed services and to operate peer-run programs, services, and businesses.* (Ongoing)

4. *Provide opportunities for statewide and regional recognition of direct care staff.* (Ongoing)

F. Effective service delivery and utilization management assures that individuals and their families receive services and supports that are appropriate to their needs.

Services System Expectations:

- Well-qualified and highly trained staff provides initial screenings and state-of-the-art assessments.
- Individuals move seamlessly between mental health, mental retardation, and substance abuse services and are easily connected to services and supports provided by non-behavioral health agencies.
- Partnerships with the criminal justice, health and human resources, and educational systems and with other public and private providers enable individuals with mental illnesses, mental retardation, or substance use disorders to access needed services and supports in a timely manner.
- Partnerships at the local, regional, and state levels support strategic planning, programming, and system improvement.

Implementation Actions:

1. *Provide timely and thorough initial screenings and assessment of individuals seeking public mental health, mental retardation, and substance abuse services.*

   a. Adopt state policy and protocols that incorporate the concepts and practices of recovery, resilience, and person-centered planning in the initial screening and assessment process and provide statewide consistency in assessing an individual's acuity, the complexity of his condition, and his level of functioning and determining the types, levels, and amounts of needed services and supports. (FY 2006)

   b. Establish minimal clinical competencies and training requirements for individuals performing initial screening and assessments. (FY 2007)

   c. Provide training and technical assistance on these protocols to CSB staff that perform initial screening and assessments. (2008-2010 biennium)

2. *Restructure the existing services system to provide integrated treatment for individuals with co-occurring diagnoses of mental illnesses and substance use disorders.*

a. Achieve consensus on the CCIS (Comprehensive, Continuous, and Integrated System of Care) model for organizing co-occurring services with the CSBs participating in the SAMHSA Co-Occurring System Improvement Grant. (FY 2006)

b. Establish system standards, practice guidelines, program and workforce competencies, and a quality improvement process to implement the CCIS model. (FY 2006)

c. Revise the DMHMRSAS administrative and funding procedures and develop guidelines to facilitate statewide implementation of the CCIS model. (2008-2010 biennium)

d. Provide technical assistance and training to CSBs on the CCIS model. (Ongoing)

3. *Restructure the existing services system to provide integrated treatment for individuals with co-occurring diagnoses of mental retardation and mental illnesses.*

a. Develop and implement statewide policy and guidance for state facilities and CSBs regarding evaluation, intervention, and disposition of these individuals. (FY 2006)

b. Establish a uniform set of standards for assessment and treatment programs that are based upon best practices and levels of support needed. (FY 2006)

c. Establish statewide, regional, and local collaboration and joint responsibility among mental health, mental retardation and substance abuse services to address the needs of these individuals. (FY 2006)

d. Establish regional statewide emergency protocols and services including specific responsibilities of the CSBs and state hospitals and training centers. (FY 2006)

e. Provide education, training, and technical assistance to clinical professionals, staff of public agencies, and families in order develop the skills and competencies required to effectively share the responsibility to collaboratively treat these individuals. (2006-2008 Biennium)

f. Train current CSB-based mobile crisis intervention teams comprised of clinical and direct care professionals to assure expertise in co-occurring mental retardation and mental illness and expand this training to traditional emergency teams of police, fire, or emergency medical response staff. (2006-2008 Biennium)

g. Develop the “next generation” of MR/MH clinical professionals by establishing formal relationships, linkages, and memoranda of understanding with Virginia community colleges, universities, and medical schools. (2006-2008 Biennium)

4. *Improve the capacity of the services system to consistently implement services utilization best practices that promote quality of life for individuals receiving services.*

a. Develop models and best practices for utilization management. (2006-2008 biennium)

b. Provide training to members of regional utilization review committees on models and best practices for utilization management. (2006-2008 biennium)

c. Support the implementation of utilization management best practices. (2006-2008 biennium)

5. *Provide opportunities for permissive regional arrangements that could be used by CSBs to support regional coordination, service delivery, and other regional management functions.*

a. Monitor and analyze rates of referrals and patterns of demand on core services. (Ongoing)

b. Pursue permissive legislation that allows CSBs to establish joint agreements that support regional coordination, service delivery, and other regional management functions. (FY 2006)

6. *Advance system transformation through the establishment of cross-systems approaches to delivering services and supports to individuals with mental illnesses, mental retardation, and substance use disorders.*

   a. Develop a system for collecting data from non-behavioral health agencies (e.g., public safety, corrections, juvenile justice, vocational rehabilitation, social services, education, housing) describing the services and supports they provide to individuals with mental illnesses, mental retardation, or substance use disorders. (FY 2006)

   b. Conduct a comprehensive assessment of the extent to which existing policies, regulations, and practices of other state agencies facilitate collaboration in addressing the needs of individuals with mental illnesses, mental retardation, or substance use disorders and their service. (FY 2007)

G. Mental health, mental retardation, and substance abuse services and supports meet the highest standards of quality and accountability.

Services System Expectations:

- Services and supports are effective and demonstrate positive outcomes.
- Providers assure that individuals and family members have information necessary to make educated and informed choices.
- Services and supports employ best and promising practices.
- Providers incorporate quality improvement structures and processes into services delivery and administrative practices
- System and provider performance and individual outcomes measure self-determination, empowerment, recovery, and resilience.

Implementation Actions:

1. *Adopt and promote best and promising practices that promote recovery, resilience, and person-centered principles and practices.*

   a. Adopt state policy defining services system expectations and incentives for the statewide adoption of best practices. (FY 2006)

   b. Revise existing services definitions to incorporate best practices, where appropriate. (FY 2006)

   c. Explore the potential for public-academic partnerships to support the statewide implementation of best practices by public and private providers. (FY 2006)

   d. Realign funding to support the delivery of best practices. (2008-2010 biennium)

   e. Support research focused on the development of promising and best practices. (Ongoing)

2. *Implement structures and processes to evaluate and improve the quality of services delivery and administrative practices.*

   a. Support efforts of the CSBs, state facilities, and licensed providers to implement and effectively utilize their quality improvement programs. (FY 2006)

b. Monitor the fidelity of implementation of evidence-based practices.

3. *Develop a system for collecting, monitoring, and using efficiency and effectiveness measures.*

   a. Review existing Department databases to determine the extent to which they incorporate program efficiency, effectiveness, and outcome measures and make necessary adjustments. (FY 2007)

VI. Conclusion: Our Call to Action

The process of developing this Integrated Strategic Plan (ISP) has been a grassroots, collaborative effort involving many people. Individuals receiving services, family members, representatives from our partners in the private sector and the academic community, CSBs, and the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) have worked on and endorsed this document as "our plan."

The ISP envisions a very different future for Virginia's public mental health, mental retardation, and substance abuse services system. Recent legislative and administration efforts to invest in community capacity, while essential, are not sufficient to transform our services system. The system's culture also must change to embrace and fully implement the principles and core values of recovery and resilience, self-determination and empowerment, and inclusion and community integration.

This is a plan that cannot just find its way to a shelf to collect dust. Transformation requires a commitment to bold and immediate action. Therefore, from the outset, the plan's focus has been more strategic than comprehensive - with emphasis on specific action items for each of seven critical success factors for system transformation. These strategic actions are intended to provide a yardstick against which future budget, legislative, and administrative actions can be measured.

This plan makes it crystal clear that Virginia must provide the greatest opportunity for meaningful community integration. Providing resources to expand opportunities for individuals to remain or be integrated or re-integrated into community life – or "a life like yours" – is not just a good idea or something to strive toward if resources are available. It is, in fact, a human right. The United States Supreme Court Olmstead decision in 1999 upheld community integration as a right under the Americans with Disabilities Act (ADA).

Decisions about resources reflect our priorities. We must transform our service system from one that has been predominantly institutionally based to one that puts the needs of the individual first and aggressively funds a wide array of state-of-the-art community service options. State facilities, as part of the community choice continuum, must be appropriately sized and utilized in a manner that ensures these intensive, often restrictive, and expensive resources serve individuals who truly need that level of care. Scarce services system resources must be managed under the principles of collaboration and shared ownership. A highly effective utilization review process must be in place to review each potential admission to a facility bed. This review process is best accomplished by a regional partnership of DMHMRSAS central office, state facility, and CSB staff and other community providers.

Virginia's public service system must be the safety net for individuals needing mental health, mental retardation, and substance abuse services. This safety net must have a wide "front door," or low threshold, for initial evaluation of any individual who potentially needs services. Quality and timely

"front door" assessments, coupled with the community resources described in this plan, would then direct individuals into appropriate, individually tailored services.

Transforming our system in this way is not only the right thing to do; it is the smart thing to do. Demands for public services are growing even as competition for local, state, and federal resources increases. We must get the most return for every cent invested in our service system. Keeping people in their communities with appropriate services and supports is not only a right of individuals in the Commonwealth; it also makes good fiscal sense. Investment in creating community capacity prevents more costly institutionalization – whether that institutionalization is in state facilities, in community hospitals, or adult or juvenile correctional facilities. We must invest resources into staff, services, and training that allow for timely, appropriate, and the highest quality assessments at the "front door" and into a variety of community options that implement best practices; incorporate individual and family choices; and truly reflect the concepts of recovery, empowerment, and self-determination.

I am pleased to represent the stakeholders who helped create this vision and this plan for Virginia's mental health, mental retardation, and substance abuse service system and to present this Integrated Strategic Plan. Envision the possibilities of what our system could look like if we take the bold action steps we have outlined in our plan.

James S. Reinhard, M.D.
Commissioner
Department of Mental Health, Mental Retardation, and Substance Abuse Services
November 2005

Appendix A
Definitions of the Core Values Self-Determination, Recovery Resilience, Person-Centered, and Consumer-Driven and the Principles of Inclusion and Participation

Self-Determination:

For mental health, self-determination means individuals have full power over their own lives, regardless of presence of illness or disability. It encompasses concepts such as free will, civil and human rights, freedom of choice, independence, personal agency, self-direction, and individual responsibility. Self-direction in the mental health system refers to individuals' rights to direct their own services, to make the decisions concerning their health and well being (with the help from others of their choice, if desired), to be free from involuntary treatment, and to have a meaningful leadership role in the design, delivery, and evaluation of services and supports. (Source: The UIC National Research and Training Center on Psychiatric Disability). Adults and children and their families have the ability to make choices in treatment options. The level of a child's involvement is dependent upon his age and developmental level.

For mental retardation, self-determination means individuals live in accordance with the principles of self-determination: freedom to live a meaningful life in the communities of their choice; authority over dollars needed for support; support to organize resources in ways that are life enhancing and meaningful; and self-and-family advocacy (adapted from the Center for Self Determination). Individuals get help from their friends, family or authorized representative (AR) as needed.

For substance use disorders, self-determination means that individuals are addressing the impact of substance use on their lives and are actively engaged in learning to live without alcohol or other mood-altering drugs in a hopeful context. As knowledge and skills related to disease management increase, so does hope, and the individual is able to make choices that support a healthy, substance-free life. This occurs as the recovery process progresses to help the individual gain awareness and manage his or her behavior towards abstinence, positive social influences and supports, constructive behaviors, responsible management of feelings and emotions, non-addictive thinking patterns, and accurate core-beliefs and rational thinking (Gorski, T.T. et al, *Relapse Prevention and the substance-abusing criminal offender: Technical assistance publication series 8.* DHHS, SAMHSA, p. 9).

Recovery and Resilience:

For mental health, recovery does not mean a "cure", or a return to "normal". It is regaining a meaningful life despite mental illness. William Anthony, Ph.D., (1993) defines recovery as a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery is a profoundly personal experience, a process of reconnecting. Hope is a big part of the process. Hope is promoted by restoring the person's morale and self-esteem, supporting his efforts to take personal responsibility for his health, and helping him develop broad lives that are not illness-dominated. Recovery involves defining oneself apart from the illness and gaining control of the illness so that it becomes only a small component of what makes up the person. For children and adolescents, it means gaining, with the support of the family, school, and community, control over important aspects of his life. Resilience means that despite overwhelming pain and suffering and, with the support of family, school, and community, the individual is able to maintain over a prolonged period a sense of hope, self-efficacy, capacity for productive schooling, and capacity for developing caring relationships.

For mental retardation, the concept of recovery does not apply in the sense that persons with mental retardation will need supports throughout their entire lives. The nature and level of support needs may change over time. With supports, persons with mental retardation are capable of living lives that are fulfilling and satisfying and that bring meaning to themselves and others they know. Resilience for persons with mental retardation is the self-confidence that comes from living a life with meaning.

For substance use disorders, recovery is an incremental process leading to positive social change, and a full return to biological, psychological, and social functioning.

Empowerment and Consumer-Driven:

For mental health, empowerment and consumer-driven means that individuals have access to information and resources and decision-making power. It involves having a range of options from which to make decisions rather than just "yes/no" or "either/or" alternatives and determining the course of one's treatment with input from professionals. Components of empowerment include self-esteem and assertiveness, hopefulness, understanding that people have rights, willingness to effect change in one's life and community, and learning to think critically with respect to one's capacities and relationships, including with institutionalized powers.

For mental retardation, empowerment and consumer-driven means that individuals and their families have choice and control over the types of services and supports they need and use. Subject to authority given by the public system and to the extent desired, individuals have control over public funding that supports them and can be creative in crafting and purchasing desired services and supports. Individuals get support from their friends, family or authorized representative (AR) as needed.

For substance use disorders, empowerment and consumer-driven means that the individual is supported in his or her recovery by others in recovery, his or her natural community, and professionals who can provide guidance and education about the recovery process. Together, they assist the individual in utilizing his or her natural resources and strengths to understand and utilize the recovery process that occurs over time.

Person-Centered:

Person-centered means that individuals and their families are supported in living lives of their own choosing, including designing and managing or participating in their individual system of supports. Individuals strive for a self-determined life that is more than their system of services and supports. They are seen as unique individuals and all assessments, interventions, and services and supports are focused on meeting his unique situation. Individuals get support from their friends, family or authorized representative (AR) as needed.

Inclusion:

Individuals are welcomed as valued members of their communities. They have community connections and actively choose meaningful ways in which they wish to be involved. Individuals have the opportunity to participate in everyday living experiences that are based on individual preferences as stipulated in Olmstead. Children are educated in the least restrictive setting with the regular classroom being the preferred site in schools. For mental retardation, individuals with differing intellectual abilities are supported in living full and productive lives, with access to supports as needed to ensure their necessary health and safety needs are adequately provided on an individual basis and enhance the attainment of their highest level of independence within their capabilities.

Participation:

Participation means that individuals are actively involved in making their own decisions and in the decisions that are guided by others for and about them. They receive the assistance they need from the public system to take responsibility for decisions in their lives and for funding allocated to support them over which they are given authority by the public system. Individuals have developed long-term relationships with friends, family, and others who have high expectations for them and their participation in activities of their choice that best promote and address their individual health and safety issue.

Appendix B
Regional Partnership and Special Populations Workgroup Participants

Region 1 Restructuring Membership List

Central Virginia CSB
Rappahannock-Rapidan CSB
Northwestern CSB
Rappahannock Area CSB
Region Ten CSB
Rockbridge Area CSB
Harrisonburg/Rockingham CSB
Western State Hospital
Augusta Medical Center
Kenmore Clubhouse – RACSB
NAMI – Fredericksburg
Snowden of Fredericksburg
Fauquier Hospital
Mental Health Association of Fauquier County
ARC of Central Virginia
ARC of Piedmont
University of Virginia Hospital
ARC of Rappahannock
Visions Clubhouse – RRCSB
Western State Advisory Board
Central Health – VA Baptist Hospital
Rockingham Memorial Hospital
DMHMRSAS

Region 2 Restructuring Membership List

Steering Committee

CO-CHAIRS

Lynn DeLacy, Northern Virginia Mental Health Institute
James A. Thur, Fairfax-Falls Church Community Services Board

Members
Jane Anthony, Parents and Associates of the Institutionalized Retarded
George Barker, Health Systems Agency of Northern Virginia
Mary Ann Beall, Mental Health Consumers Association
John Beghtol, Western State Hospital
Allen Berenson, Fairfax-Falls Church Community Services Board
Roger Biraben, Loudoun Community Services Board
Ray Bridge, Laurie Mitchell Employment Center/Northern Virginia Mental Health Consumers Association
Jessica Burmester, Fairfax-Falls Church Community services Board
Mark Diorio, Northern Virginia Training Center
Tom Geib, Prince William Community Services Board
Mike Gilmore, Alexandria Community Services Board
Amanda Goza, Northern Virginia Mental Health Institute
Wendy Gradison, Psychiatric Rehabilitation Services, Inc.

Betsy Greer, Arlington Community Services Board, /Arlington Alliance for the Mentally Ill
Waja Grimm, Parent and Prince William Community Services Board Member
Ann Marie Hermann, Older Adults Advocate
Joe Hinshaw, Northern Virginia Mental Health Institute Advisory Board
Sharon Jones, Fairfax-falls Church Community services Board
Leslie Katz, Northern Virginia Training Center
Henriette Kellum, Arlington Community Services Board
Cindy Kemp, Arlington Community Services Board
Edwin H. Kline, Sr., Northern Virginia Mental Health Institute
Tom Maynard, Loudoun Community Services Board
Lynn Mc Fadden, Snowden at Fredericksburg
Cathy Pumphrey, Fairfax-Falls Church Community Services Board
Rita Romano, Prince William Community Services Board
Lou Rosato, Northern Virginia Mental Health Institute
Carol Urlich, National Alliance for the Mentally Ill-Northern Virginia
Leslie Weisman, Arlington Community Services Board
Alan Wooten, Fairfax-Falls Church Community Services Board
L. William Yolton, National Alliance for the Mentally Ill-Northern Virginia

Children and Youth Work Group

Chair

Allen Berenson, Fairfax-Falls Church Community Services Board

Members
Dr. Cheryl Al-Mateen, Virginia Treatment Center for Children
George Barker, Health Systems Agency of Northern Virginia
Janet Bessmer, City of Alexandria
Bonita Bolden, Psychiatric Institute of Washington
John Boyd, Alexandria Community Services Board
Alicia Bush, Prince William Community Services Board
Lorrie Cocolin, Dominion Hospital
Victor Evans, Prince William County
Sharon Frost, Northern Virginia Family Service
Julie Garcia, Inova Fairfax Hospital
Maureen Gill, Inova Fairfax Hospital
J. Gillespie, Loudoun County
Lee Goldman, Arlington County
Michael Goodman, Riverside Hospital
Brian Hill, Virginia Treatment Center for Children
Judy Hines
Leslie Kelley, Graydon Manor
Jim King, Snowden at Fredericksburg
Gail Ledford, Fairfax County Department of Family Services
Diana Manganelli, Arlington County
Lynn McFadden, Snowden at Fredericksburg
Erin McNamara, Psychiatric Institute of Washington
Kathy McNamara
Sharon Minter, City of Manassas
Felix Nathan, Riverside Hospital
Sandy Porteous, PHILLIPS Programs

L. Jean Reynolds, Dominion Hospital
Winifred Ridley, Riverside Hospital
Laura Rivers, Mountain Manor Treatment Center
Barbara Shue, Commonwealth Center for Children and Adolescents
Debra Schuetz, Loudoun County
Lisa Scott, Snowden at Fredericksburg
Rob Smith, Graydon Manor
Dr. Aradana Sood, Virginia Treatment Center for Children
Kola Sosola, Psychiatric Institute of Washington
Lise Syed, Dominion Hospital
Kim Thomas, Psychiatric Institute of Washington
Jim Thur, Fairfax-Falls Church Community Services Board
Toni Tupper, Inova Fairfax Hospital
Mercedes Wilson, Alexandria County
Dr. Thomas Wise, Inova Fairfax Hospital
Kirsten Woodward, Psychiatric Institute of Washington

Older Adults Work Group

Chair

Anne Marie C. Hermann, Older Adults Advocate

Co-Chairs

Henriette Kellum, Arlington Community Services Board
Richard Spector, Fairfax-Falls Church Community Services Board

Members
Donna Baker, Sunrise Assisted Living of Springfield
Joanne Burke, Potomac Center, Genesis Healthcare
Tam Cummings, Potomac Center, Genesis Healthcare
Barbara DeAngelis, Alzheimer's Association, National Capital Area Chapter
Sharon Dreyer, Fairfax County Department of Housing, Retired
Elaine Eckert, Fairfax-Falls Church Community Services Board
Sharon Flanagan
Julie Garcia, Inova Fairfax Hospital
Melynda Griggs, Fairfax County Department of Family Services
Karen Hannigan, Prince William Area Agency on Aging
Kitty Harold, Virginia Hospital Center
Evelyne Hatfield, Prince William County
Cynthia Irwin, Loudoun Community Services Board
Karen Jensen, Family Member
Elissa Leopold, Georgetown University Graduate Nursing Student
Nora Locke, Fairfax-Falls Church Community Services Board
Terri Lynch, Arlington Agency on Aging
Pam McDonald, Virginia Hospital Center
Fran McWhorter, Northern Virginia Aging Network
Judy Ratliff, Private Mental Health Practitioner
Jennifer Robinson, Fairfax County Health Department
Odile Saddi, Arlington Aging and Disability Services
Shauna Severo, Fairfax County Health Department
James Schmidt, Virginia Hospital Center

Margo Tolliver, Community Volunteer
Rhonda Williams, Alexandria Community Services Board
Erica Wood, Virginia Commonwealth Council on Aging

Mental Health Work Group

Chair

Sharon Jones, Fairfax-Falls Church Community Services Board

Members
George Barker, Health Systems Agency of Northern Virginia
Roger Biraben, Loudoun Community Services Board
Joe Bullock, Arlington Community Services Board
Lynn DeLacy, Northern Virginia Mental Health Institute
Kay Dicharry, Loudoun Community Services Board
Mark Diorio, Northern Virginia Training Center
Sally Garrett, Northern Virginia Mental Health Institute
Amanda Goza, Northern Virginia Mental Health Institute
Wendy Gradison, Psychiatric Rehabilitation Services, Inc.
Dr. Colton Hand, Fairfax-Falls Church Community Services Board
Trudy Harsh, Fairfax-Falls Church Community Services Board
Alfred L. Head, Northern Virginia Mental Health Institute
Sharon W. Hoover, Prince William Community Services Board
Sharon Jones, Fairfax-Falls Church Community Services Board
Jennifer Kane, Northern Virginia Mental Health Institute
Leslie Katz, Northern Virginia Training Institute
Jim Kelley, Fairfax-Falls Church Community Services Board
Henriette Kellum, Arlington Community Services Board
Jim Kelley, Fairfax-Falls Church Community Services Board
Cindy Kemp, Arlington Community Services Board
Edwin H. Kline, Northern Virginia Mental Health Institute
Carol Layer, Alexandria Community Services Board
Sharon Letourneau, Northern Virginia Mental Health Institute
Laurence R. Levine, Northern Virginia Mental Health Institute
Walt Mahoney, Arlington Community Services Board
Joel McNair, Pathway Homes, Inc.
Russell Payne, DMHMRSAS
Dave Redman, Fairfax-Falls Church Community Services Board
Rita Romano, Prince William Community Services Board
Lou Rosato, Northern Virginia Mental Health Institute
Kerrie Shrewsbury, Northern Virginia Mental Health Institute
James Thur, Fairfax-Falls Church Community Services Board
Carol Ulrich, National Alliance for the Mentally Ill-Northern Virginia
Leslie Weisman, Arlington Community Services Board
Alan Wooten, Fairfax-Falls Church Community Services Board

Individuals with Mental Retardation Work Group

Chair

Mark Diorio, Northern Virginia Training Center

Members
Musa Ansari, DMHMRSAS Office of Human Rights
Jane Anthony, Parents and Associates of the Institutionalized Retarded
Silva Bey, Community Living Alternatives
Mary Burger, Loudoun Community Services Board
Jessica Burmester, Fairfax-Falls Church Community Services Board Member
Phillip Caldwell, Alexandria Community Services Board
Mark Diorio, Northern Virginia Training Center
Ellen Einstein, Fairfax-Falls Church Community Services Board
Fred Firestone, Loudoun Community Services Board
Russell Garth, Parent
Waja Grimm, Parent and Prince William Community Services Board Member
Leslie Katz, Northern Virginia Training Center
Jennifer F. Kurtz, Arlington Community Services Board
Herk Latimer, Fairfax Human Services Council
Nancy Mercer, The Arc of Northern Virginia
Brian Miller, Prince William Community Services Board
Johannes Rojahn, George Mason University, Center for Cognitive Development
Louis Rosato, Northern Virginia Mental Health Institute
Ann Sale, Parent and Prince William Community Services Board Member
Karen Tefelski, VaACCESS
Lyanne Trumbull, Fellowship Health Services, Inc.
Jackie Turner, Prince William Community Services Board
Pat Vinson, Job Discovery, Inc.
Paul Wexler, Central Fairfax Services, Inc.
Joanna Wise-Barnes, Arlington Community Services
Alan Wooten, Fairfax-Falls Church Community Services Board

Individuals with Co-Occurring Mental Retardation/Mental Illness Work Group

Chair

Mark S. Diorio, Northern Virginia Training Center

Members
Jane Anthony, Parents and Associates of the Institutionalized Retarded
Jessica Burmester, Fairfax-Falls Church Community Services Board
Phillip Caldwell, Alexandria Community Services Board
Ellen Einstein, Fairfax-Falls Church Community Services Board
Fred Firestone, Loudoun Community Services Board
Steve Garcia, Loudoun Community Services Board
Russell Garth, Parent
Susan Greene, Community Systems, Inc.
Leslie Katz, Northern Virginia Training Center
Cindy Kemp, Arlington Community Services Board
Cynthia Koshatka, Fairfax-Falls Church Community Services Board
Jennifer F. Kurtz, Arlington Community Services Board
Nancy Mercer, The Arc of Northern Virginia
Brian Miller, Prince William Community Services Board
E. Geronimo Robinson, Alexandria Community Services Board
Saranna Rankin, Prince William Community Services Board
Lou Rosato, Northern Virginia Mental Health Institute

Jackie Turner, Prince William Community Services Board
Pat Vinson, Job Discovery, Inc.
Leslie Weisman, Arlington Community Services Board
Joanna Wise-Barnes, Arlington Community Services Board
Alan Wooten, Fairfax-Falls Church Community Services Board

Private Psychiatric Hospitals Work Group

Co-Chairs

Lynn DeLacy, Northern Virginia Mental Health Institute
James A. Thur, Fairfax-Falls Church Community Services Board

Members
George Barker, Health Systems Agency of Northern Virginia
Roger Biraben, Loudoun Community Services Board
David Carlini, Prince William Hospital
Cynthia Chambers, Inova Health System
Bryan Dearing, Dominion Hospital/Northern Virginia Community Hospital
Dr. Jim Dee, Inova Mount Vernon Hospital
Mark Diorio, Northern Virginia Training Center
Shawn Gallagher, Inova Alexandria Hospital
Julie Garcia, Inova Fairfax Hospital
Mike Gilmore, Alexandria Community Services Board
Amanda Goza, Northern Virginia Mental Health Institute
Kitty Harold, Virginia Hospital Center
Alexander Isaac, Inova Fairfax Hospital
Sharon Jones, Fairfax-Falls Church Community Services Board
Elizabeth Leeth, Inova Fairfax Hospital
Tom Maynard, Loudoun Community Services Board
Lynn McFadden, Snowden at Fredericksburg
L. Jean Reynolds, Dominion Hospital, Northern Virginia Community Hospital
Anne Rieger, Inova Mount Vernon Hospital
Rita Romano, Prince William Community Services Board
Jim Scott, Inova Health System
Catherine Stuart, Inova Loudoun Hospital
Gail Sullivan, Fairfax-Falls Church Community Services Board
Carol Ulrich, National Alliance for the Mentally Ill-Northern Virginia
H. Patrick Walters, Inova Health System
Leslie Weisman, Arlington Community Services Board

Structural Work Group

Chair

Cindy Kemp, Arlington Community Services Board

Members
Phil Bradbury, Alexandria Community Services Board
Mike Gilmore, Alexandria Community Services Board
Dean Bonney, Arlington Community Services Board
Mary Burger, Loudoun Community Services Board
Jessica Burmeister, Fairfax-Falls Church Community Services Board
Jim Thur, Fairfax-Falls Church Community Services Board

Stephanie Foran, Loudoun Community Services Board
Ray Coffey, Prince William Community Services Board
Tom Geib, Prince William Community Services Board
Lynn DeLacy, Northern Virginia Mental Health Institute
Mary Ann Beall, Mental Health Consumers Association

Region 3 Restructuring Membership List

Chair

Ron Allison, Cumberland Mountain Community Services Board

Vice Chair

Hunter P. Widener, Highlands Community Services

Members
Cynthia McClure, Southwestern Virginia Mental Health Institute
Derek Burton, Mount Rogers Community services Board
Lisa Moore, Mount Rogers Community Services Board
Sandi Goodman
Lynn Chenault, New River Valley Community Services
Sam Dillon, Planning District 1 Behavioral Health Services
Joe Fuller, Dickenson County Community Services Board
Dale Woods, Southwestern Virginia Training Center
James Turner
Martin Felker
Carol Rivera
Judy Salyer, Consumer and Family Involvement Project
Everett Franklin, Family Support Project

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People's Place, Colonial Community Services Board
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Appendix C
Services System Strengths and Opportunities, Challenges, and Emerging Trends

1. Strengths and Opportunities

a. Increasing consumer and family activism, involvement, and expectations

b. Successful regional strategic planning and collaboration efforts among CSBs, state facilities, advocates, other pubic and private providers, and interested citizens

c. Public-private partnerships and regional services that create economies of scale and increase service capacity

d. Existence of a local system providing high quality services across the entire Commonwealth

e. New psychotherapeutic medications, assistive devices, and other medical and medication advances have improved consumers' abilities to live productively in the community

f. History of innovation, flexibility, and creativity by CSBs and state facilities in responding to the needs of individuals receiving services

g. Skilled and experienced work force that is dedicated to meeting the needs of consumers with commitment and compassion

2. Challenges and Critical Issues

a. Lack of community service capacity to address existing demand for services across all program areas, resulting in historic over reliance on state facility services, waiting lists, and gaps in service options

b. Inconsistencies in accessing an array of services from one CSB to another and between consumers with and without Medicaid coverage

c. Limited applications of evidence-based and promising practices

d. Lack of alternatives to inpatient psychiatric care and difficulties accessing beds due to:
   i. the lack of child/adult psychiatric beds in community hospitals
   ii. community beds that may be available but are not accessible, and
   iii. increased out-of-region demands on beds

e. Loss of private sector inpatient capacity due to healthcare economics that have discouraged the development or sustainability of psychiatric units and other services

f. Insufficient numbers, structures, and types of providers with the skills necessary to meet the needs of the most challenging consumers, including individuals with co-occurring disabilities

g. Address low Medicaid provider rates and eligibility levels and implement policy guidance to further align State Medical Assistance Plan services with the recovery and resiliency model

h. Significant deficiencies in state facility and community program infrastructure and limited funding for infrastructure maintenance and improvements

i. Fragmentation across agencies providing services and supports to individuals with mental illnesses, mental retardation, and substance use disorders

j. Lack of low-cost, adequate, and appropriate housing and over reliance on assisted living facilities that are often concentrated in areas experiencing an influx of out-of-region consumers

k. Lack of medical resources for under insured and indigent consumers who are not covered by Medicaid, increasing their medical fragility

l. Shortage of guardians and legally authorized representatives

m. Noncompetitive salary compensation that compromises recruitment and retention of qualified staff

n. Lack of mechanisms to collect data and analyze trends

3. Emerging Trends

a. Demographic changes, including:
   i. Rapidly increasing population growth, particularly in the Commonwealth's "Golden Crescent
   ii. Declining population in Southwestern Virginia and many cities
   iii. Increased cultural and linguistic diversity in many areas of the Commonwealth
   iv. Aging of Virginia's population generally

b. Increasing criminal and juvenile justice populations with mental illnesses and substance use disorders

c. Increasing numbers of individuals requiring intensive levels of community-based services

d. Spiraling cost of medications

e. Shortages of critical health care professionals (psychiatrists, occupational and physical therapists and nurses) as increasing numbers of professional and direct care staff are reaching the age of retirement

f. Federal proposals to cap and/or completely restructure Medicaid

g. Anticipated reduction and caps in Section 8 funds

Appendix D
Summary of Regional Strategic Planning Partnership Goals, Objectives, Action Steps and State-Level Recommendations

REGION 1 STRATEGIC PLAN – WESTERN VIRGINIA

Goal #1: Address the regional critical need for acute care psychiatric beds in the private sector.

1. Identify funding to allow for regional purchase of acute care services.
    a. Target reinvestment funding sufficient to purchase short-term treatment for commitments when Western State Hospital is full.
    b. Manage acute care regionally through an active utilization management committee in collaboration with private providers.
    c. Work towards regional pilot projects where the goal is the diversion of all Western admissions.
    d. Expand contracting ability for acute care services to facilities beyond the Health Planning Region.
    e. Reserve admissions to Western State Hospital to individuals needing longer term care while ensuring sufficient resources at Western in order to provide acute care services for those who cannot be served in community settings.
2. Develop process for evaluating the quality of care provided by private providers receiving reinvestment funding.
    a. Solicit input from private providers on the process for evaluating services.
    b. Formulate committee of CSB quality managers to determine appropriateness, access, outcome and general satisfaction with care provided.

Goal #2: Develop a Crisis Stabilization Program to better address needs of individuals with co-occurring needs related to mental health and substance abuse.

1. Address the need for support for individuals with mental retardation who experience short term and extreme behavioral challenges.
    a. Work with the new director at the Central Virginia Training Center to consider recommendations of a committee comprised of staff from Western State Hospital, Central Virginia Training Center, and Central Virginia Community Services.
    b. Pilot a recommended program, which would establish a special intervention team to allow stabilization to occur in the home residence including consultation, temporary staff support, and follow up.
    c. Establish a crisis stabilization unit at Central Virginia Training Center to provide intervention for individuals who cannot safely be maintained in their own home due to risk of harm to self or others.
2. Address the needs of individuals in crisis who require intensive services and avoid inappropriate hospitalization at Western State Hospital.
    a. Utilize new regional State general funds to enhance existing service offerings at both New Hope and Boxwood treatment programs to improve capacity to accept more challenging referrals.
    b. Target some regional funding to provide additional bed purchase capability specifically for SA issues and detox services to supplement funds in the existing SA diversion project.

c. Get consultation and additional staff training for New Hope and Boxwood to increase staff knowledge and expertise in the effective management and treatment of individuals with co-occurring disorders.
d. Explore other avenues of support including fee-generating capability of crisis stabilization services.
e. Have regional Utilization Management Team track consumers served through these activities collecting relevant data to evaluate outcomes.

Goal #3: Improve collaboration for regional children's services.

1. CSBs to serve as the sole entry point into publicly funded mental health care**.**
   a. CSB case managers must manage the cases of all children accessing public funds for mental health care.
   b. Assessment of the suitability of outpatient care must be made by CSB staff prior to the implementation of any more intensive, publicly funded intervention.
   c. Access to CCCA, including for 10-day evaluations, made available only to those deemed appropriate for that service by CSB staff, with justification for not using less intensive, community-based services provided.
2. Strengthen resources within the CSB to solidify its position as the children's mental health authority**.**
   a. Legitimize the role of the CSB case manager for discharge planning of CCCA patients through service funding to enable adequate staffing and involvement in the planning process.
   b. Develop consultative liaison, perhaps through video-conferencing, with CCCA to allow CSBs access to the expertise of child psychiatrists, both for cases shared by CCCA and the CSB as well as for cases being maintained and receiving continuing care in the community.
   c. Improve understanding of community resources and of the factors affecting transition from adolescent to adult services, such as access to entitlements, by providing training to CCCA staff in the community.

Goal #4: Provide services and supports outside of traditional catchment area boundaries.

1. Provide a PACT team for every CSB currently without such team.
   a. Allocate funding to new teams which will be comprised of case management, residential support and psychiatric nursing staff with specific caseloads targeted to support stable community placement.
   b. These teams will support many of the individuals identified in priority DAP plans for FY 05.
   c. These collaborations will focus resources on improving responsiveness to individuals whose needs include case management, medications management, day rehabilitation, transportation and housing.

Goal #5: Replace Boxwood facility.

1. Using a previously completed feasibility report, prepare a financial analysis for debt service to construct a replacement facility using designs already completed.
   a. Survey participating CSBs to assess willingness to increase per diem payments to service long term debt.
   b. Present feasibility study and financial analysis to potential financing sources.

c. Secure financing and adopt appropriate borrowing resolutions from local governments of the RRCSB.
d. Complete architectural development and bidding.
e. List existing Boxwood property for sale.
f. Begin construction for replacement facility.

Regional Partnership Recommendations for State-Level Action:

1. Statewide Medicaid rates for core CSB services need to be evaluated and raised to be more reflective of the actual cost of providing services.
2. State funding needs to address the needs of individuals who do not qualify for Medicaid.
3. Pharmaceuticals represent an ever-increasing percentage of health care budgets in Health Planning Region I. The rising cost of medications must be addressed.
4. Legislation should be pursued to address needed training and education for sheriffs and magistrates regarding individuals with Temporary Detention Orders, etc.
5. Re-evaluate the current regional make-up in light of marked changes in population, demographics, and urban/rural balance over the past 25 years.

REGION 2 STRATEGIC PLAN – NORTHERN VIRGINIA

Strategic Direction for Mental Health Services:

1. Increase mental health community-based services to prevent psychiatric hospitalization or criminal diversion, whenever possible.
2. Increase mental health community-based services to discharge hospitalized patients when they are ready for community services.
3. Maintain the level and quality of inpatient services currently available to residents until better data on future demand is available.
4. Implement recovery principles throughout the mental health service system.
5. Provide readily available services.

Regional Work Group Next Steps:

1. Establish a regional work group to deal with the concerns of children and youth who have serious emotional disturbance.
2. Move recovery principles into practice.
3. Review options to meet the demand for inpatient care, including:
   a. Diversion of consumers to community programs,
   b. Use of public and private beds for TDOs,
   c. Need to re-bid contracts,
   d. Continuity of care for patients discharged from private hospitals into the care of CSBs,
   e. Need for additional community-based resources, and
   f. Increasing psychiatric bed capacity.
4. Publish a workbook for all potential and current NGRI patients to explain the NGRI system, patient rights and their recourses.
5. Develop an informational brochure to aid awareness of dual diagnosis (MR/MI).

6. Establish a regional work group to deal with the concerns of older adults with mental illness.
7. Continue to explore ways to work together more efficiently in areas of training, administrative processes and information technology on behalf of Northern Virginia programs.

Regional Partnership Recommendations for State-Level Action:

1. Improve Virginia's Medicaid Assistance Plan by:
   a. increasing eligibility level from 80% to 100% of federal poverty level
   b. setting rates at a level sufficient to cover costs of all Medicaid services
   c. expanding the array of services, e.g., PACT as a bundled service.
2. Fully fund the entire continuum of care, including state facilities, private hospitals and community-based services.
3. Foster greater use of private sector providers by ensuring that they are reimbursed adequately by all sources, including public payers such as Medicaid and DMHMRSAS as well as private insurance companies.
4. Maintain an adequate capacity of psychiatric inpatient beds and community-based services.
5. Begin funding the recommendations contained in "One Community," the final report of the Olmstead Task Force.
6. Maintain the current bed capacity at NVMHI in light of increasing population and proposed reductions in the number of beds in the private sector.
7. Establish a Center for Excellence at NVMHI focused initially on sharing the approaches that have led to significant reductions in seclusion and restraint.
8. Re-bid the State contract for inpatient psychiatric care to include the option of pre-purchasing beds.
9. Actively promote the Recovery Principles throughout the Commonwealth.
10. Reestablish an Office of Consumer and Family Affairs in DMHMRSAS.
11. Establish and fund consumer empowerment training throughout the Commonwealth.
12. Request that the State design and implement, in collaboration with the private sector, a system for properly addressing the growing need for services for older adults with mental illness and persons with dementia who have psychiatric symptoms.
13. Request that DMHMRSAS carefully consider the recommendations from the regional work groups studying how to better serve persons with a dual diagnosis of mental illness and mental retardation.
14. Coordinate regional and state service issues.
15. Fully fund medications provided through the State Aftercare Pharmacy for discharged state hospital and non-hospitalized consumers
16. Identify educational materials needed for General Assembly.
17. Implement consumer participation in policy and program levels.

REGION 3 STRATEGIC PLAN – FAR SOUTHWEST VIRGINIA

1. Increase community-based services.

a. Effective utilization of FY 05-06 funds for expanded services; DAP, PACT MR Waivers, etc.
b. Continue advocacy for funding to expand CSB/BHS infrastructure.

2. Reduce utilization of SWVMHI.
   a. Initiation of Inpatient POS project is targeted to maintain more predictable acute admissions.
   b. Region's dependency on SWVMHI prohibits bed closures at this time, will focus efforts on census reduction.
   c. Long range goal of bed closures within 5 years IF Inpatient POS projects are adequately funded and there are no reductions in private psychiatric beds.
3. Provide acute psychiatric treatment through inpatient POS projects to treat consumers closer to home and facilitate multi-system partnering for local psychiatric care.
4. Expand DAP plans for FY 05-06 to reduce Institute utilization, expand community-based resources and promote positive outcomes for SPMI consumers identified for these services.
   a. Free up admission beds now tied up by consumers waiting for ERS beds.
   b. Implement approximately 14 DAP plans.
5. Form a second PACT program in the region to effectively utilize state funds for a dynamic community based intervention.
   a. Improve treatment outcomes, maintain placement in community, reduce utilization of inpatient services, increase participation in recovery/treatment plans and address co-morbid issues that complicate treatment
   b. Serve 75 SPMI consumers in the Mt Rogers CSB catchment area.
6. Secure MR Waiver Slots for those consumers on the Community Urgent Waiting lists.
7. Access facility-based MR Waiver slots for MR consumers in SWVTC and SWVMHI.
8. Increase public education/awareness of mental health, mental retardation and substance abuse issues.
   a. Implement public education MR/MI program, "Pathways", which targets both the public and increases direct care staff awareness.
   b. Partner with consumers and family members in MH awareness efforts such as "Consumer & Family Involvement Project".
9. Continue consumer and family involvement in strategic planning and decision making for the region.
   a. Include stakeholders as voting members of the Southwest VA Behavioral Health Board's to demonstrate the Region's commitment to community involvement.

Regional Partnership Recommendations for State-Level Action:

1. Previous proposed legislation to raise the income level for Medicaid eligibility must be passed to expand coverage for uninsured consumers.
2. State agencies actively pursue grant opportunities to increase health services for rural Virginians, seeking to partner with local public and private entities in accessing possible grant funding.
3. Substance Abuse Services should be adequately funded to address the overwhelming numbers of dually diagnosed consumers and provide detoxification services in settings other

than acute psychiatric facilities. The SA Medicaid initiative must be funded by the General Assembly for community based SA services development.

4. Dental Services for consumers is a vast unmet need and should be addressed as the public health issue that it is. Medicaid should cover dental care.
5. Virginia DOH & DMHMRSAS coordinate efforts to recruit board certified physicians (psychiatrists) and licensed mental health professionals for rural Virginians.
6. DMHMRSAS partners with CSB/BHS and State facilities to advocate for legislative action to replicate evidence based practices such as mental health courts to increase services for consumers in the correctional system that need MH/MR/SA supports or services.

REGION 4 STRATEGIC PLAN – CENTRAL VIRGINIA

Goal #1: Implement a Region IV/SVTC Project.

1. Implement a Region IV/SVTC Emergency Bed Project for persons with mental retardation.
   a. Maintain two permanent "reserved" emergency beds (one male and one female) at SVTC on the Behavioral Unit to provide intensive services when other local behavioral efforts have not worked
   b. Regionally manage admissions from and discharges from these emergency beds
   c. Regionally pool several Waiver slots to guarantee that individuals will be able to be discharged when an appropriate community bed is located.
2. Establish a Region IV Emergency Residential Program in an empty on-grounds cottage at SVTC so individuals can be moved from their community residence for a short time to address behavioral challenges.
   a. Through each CSB, provide 24 hour staffing and transportation and expenses.
   b. Through SVTC, provide limited staff support from its behavioral, clinical, and medical staff.
   c. Obtain DMAS/DMHMRSAS assignment of 4 new MR Facility Waiver slots to support this project.
3. Train local staff and family members to work with individuals when they return home.
4. Provide funding for respite care in facilities such as Camp Baker as a "step down" from these projects.

Goal #2: Review Clinical Program Design and Mission of Regional SA Services Operated at Turning Point.

1. Establish a regional clinical review workgroup to evaluate service populations and clinical programming at Turning Point and maintain SAPT Block Grant Funding.
2. Develop regional wrap-around services for opiate addiction.
3. Develop flexible regional purchasing agreements.

Goal #3: Develop self-contained SA treatment in jails

1. Establish a six-week Intensive Addictions Focus program based on the Henrico County jail's social learning recovery model programs in three jails identified by Region IV Reinvestment Jail Team. In each facility:
   a. Dedicate one entire living area (dayroom, POD) in each participating facility for inmates who volunteer to participate in a self-help recovery program.

b. Receive program description, schedule of activities, and list of resource materials from the Henrico County Sheriff's Department and Henrico CSB.

c. Temporarily transfer a small group of inmates who demonstrate a strong interest in the program to the Henrico County Jail to complete the Intensive Addictions Focus program and return to their facilities to provide leadership as senior members of the new program.

d. Arrange for the Henrico County Jail and Henrico CSB staff to provide consultation to the project's clinical staff.

Goal #4: Study alternatives to inpatient care for adults and/or children.

1. Examine the feasibility of establishing sub acute crisis stabilization and supervised residential services for children and adults.
   a. Explore the need for statutory or regulatory changes that would provide for or allow locked or otherwise controlled residential facilities.

Goal #5: Establish ways to enhance private/public coordination of care.

1. Formalize service access structure and communication processes to provide collaboration that is necessary to ensure that bureaucratic systems to not impede access to appropriate services.

Regional Partnership Recommendations for State-Level Action:

1. The Regional Strategic Planning Partnership adopted a goal of prioritizing population groups and working toward uniform service availability across jurisdictions. Region IV proposes to use additional regional and local funding to move in this direction.
2. Certain benefits and services should be universal. When and if additional resources become available, a second level of services could be implemented. A third level of services may be created when localities use their local tax dollars to support certain services.
3. The State should adequately fund a minimum level of services to assure consistent services throughout the region.
4. DMHMRSAS needs to work with the Department of Medical Assistance Services so that Medicaid supports services that MH deems essential for recovery. Medicaid must be revamped to become more flexible.
5. The services system must be responsive to the need of persons who have Medicaid as a payer as well as those who do not.
6. DMHMRSAS should seek simplification in administrative processes and reporting.
7. The system needs a more coordinated approach at the State level, one that supports a single vision for a system of care.
8. DMHMRSAS leadership is essential in defining short-and long-term role of State facilities.
9. Facilities should be encouraged to put in practice reinvestment and restructuring concepts that complement and support those in the local system.

REGION 5 STRATEGIC PLAN – EASTERN VIRGINIA

STRATEGIC ISSUE # 1: COMMUNITY-BASED SERVICES

Goal 1: Implement a children's services demonstration project with a local, CSB-managed residential component, completely integrated with CBS services, to model a system of care approach.

Goal 2: Advocate re-focusing Medicaid away from a medical model toward support of a recovery model

Goal 3: Partner with advocates to build a critical mass of support for mental illness prevention and mental health promotion

Goal 4: Build programming around mental health and substance abusing consumers who enter the system through criminal justice

a. Increase education about mental illness and substance abuse for judges, attorneys and law enforcement officials
b. Design interventions to precede incarceration
c. Advocate/support additional drug and mental health courts

Goal 5: Fund and implement a pilot "Recovery House" model as a crisis intervention and stabilization alternative to hospitalization (Components would include step down, diversion from acute care, peer support, support groups, community liaison)

Goal 6: Explore supporting and expanding employment and vocational opportunities for consumers (without adversely impacting benefits)

Goal 7: Establish a Center of Excellence at SEVTC, with an outreach component similar to a PACT for MR consumers

STRATEGIC ISSUE # 2: COLLABORATION

Goal 1: Establish collaborative relationships with non-traditional partners

a. Seek out collaboration with the military, business community, faith community, educational institutions, private medical sector and foundations
b. Foster collaborations to develop access to leadership talent

Goal 2: Build a focused regional advocacy initiative to involve and educate consumers, families, local and state elected officials, and judges around mental health, substance abuse and mental retardation issues

a. Identify sub-regional issues
b. Create and disseminate a consistent message
c. Provide leadership and guidance to empower advocates

Goal 3: Explore cross-jurisdictional linkages

a. Identify geographic centers for shared services (e.g., – Churchland, Suffolk/Franklin)
b. Research transportation options to improve effectiveness and efficiency of community-based service delivery

Goal 4: Adopt and promote a "no wrong door" philosophy within CSB disability areas and among other local agencies in support of a "whole person" approach to services

a. Streamline access to intake
b. Expand cross training
c. Articulate a commitment to customer service and train to support it
d. Explore opportunities for more proactive transitions (from adolescent to adult services, from one jurisdiction to another)

Goal 5: Maintain and support HPR-5 partnership

STRATEGIC ISSUE # 3: FUNDING

Goal 1: Reduce dependence on Medicaid

a. Assess viability of future Medicaid funding
b. Explore opportunities for public-private contracts with fee-splitting arrangements and management services
c. Build in-house capacity for revenue generation

Goal 2: Aggressively advocate for increased funding

a. Pursue strategic partnerships to support funding requests
b. Build advocacy network to strengthen voice

Goal 3: Consolidate administrative processes in smaller jurisdictions (Ex. – purchasing)

Goal 4: Explore private sector alternatives to state pharmacy services

Goal 5: Ensure support for current level of funding by using evidence-based practices, delivering on effective outcome measures and effectively utilizing funds for expanded services

STRATEGIC ISSUE # 4: QUALITY OF CARE

Goal 1: Conduct a cost-benefit analysis of current utilization of high-cost children's services, including assessment of Medicaid, CSA and local funding supports

Goal 2: Adopt a commitment toward requiring evidence-based practice in all programming

Goal 3: Support a cultural shift from quality assurance (retrospective) to quality improvement (prospective)

a. Explore and support relationships between chart reviews and the human factor
    - Consumer satisfaction surveys
    - Consumer involvement on quality improvement councils

Goal 4: Establish system-wide accountability to reduce paperwork without sacrificing quality

a. Address inconsistent licensure interpretation and documentation requirements (State-level action)
b. Identify and address inconsistencies between licensing and Medicaid regulations (State-level action)
c. Create core forms for state-wide use
d. Develop uniform data collection and data sharing protocols and systems

STRATEGIC ISSUE # 5: HUMAN RESOURCES

Goal 1: Broaden regional training efforts

a. Develop region-wide opportunities to accrue contact hours and other continuing education
b. Expand use of technology for training and competency development
c. Partner with local educational institutions to develop "real world" curricula, improve meaningful internships and establish "MSW cohorts" within agencies

Goal 2: Share recruitment innovations

Goal 3: Establish a regional Human Services Leadership Academy to develop skills in

Leadership, management and supervision throughout CSB staff

STRATEGIC ISSUE # 6: RURAL ISSUES

Goal 1: Advocate for reimbursement differential for rural areas to compensate for unique services delivery issues, such as travel costs

Goal 2: Explore technology to improve access to training for staff in rural agencies

Goal 3: Explore collaboration in benefits procurement and management

HPR-5 PARTNERSHIP RECOMMENDATIONS FOR STATE-LEVEL ACTIONS

Administrative Requirements to Move From a Patriarchal Medical Model to a Recovery Model.

1. Review all administrative requirements that are in State Board policy, the performance contract, CCS, licensure regulations and human rights regulations with the goals of:
    - Negotiating annually with the local Boards to reduce paperwork requirements by an established percentage;
    - Aligning regulations in support of the recovery model; and
    - Eliminating the layering of regulations and coordinating the alignment of regulations.
2. Review the performance contract for relevance and effectiveness, and to focus on the requirements of the primary payor.
3. Adopt same standards of accountability for public and private provider.
4. Exercise leadership to resolve conflicts between regulatory interpretations.
5. Accept accreditation and HIPAA standards in lieu of, rather than in addition to, departmental standards wherever applicable.

Department's Structure and Role as Partner

1. Reorganize the Department around function versus disability area.
2. Eliminate separate Assistant Commissioners for facilities and communities; create one Assistant Commissioner to serve both.
3. Demonstrate commitment to the state-local partnership through re-organization, policy development and proactive, inclusive problem solving.

Resource Development to Assure Some Core Level of Services Regardless of Service Setting

1. Create a dedicated funding stream for CSBs.
2. Adopt and support the concept of funded plans of care in which funding is attached to the consumer as he or she moves through the system.
3. Ensure current levels of funding; advocate against decreases in Medicaid funding.
4. Aggressively pursue means by which to increase the total amount of available funding:
    - Advocate for increased Medicaid reimbursement;
    - Advocate for increased percentage of individuals eligible for Medicaid based on diagnosis;
    - Sell downsized state facilities, build smaller complexes and re-direct savings to local CSBs
5. Assure that CSBs will be the sole provider of case management services
6. Create and implement a plan to articulate how the Department will respond to future funding changes, such as:
    - Medicaid changes at the federal level

- State funding reductions
- Inadequate and stagnant reimbursement levels
- Reductions in covered services
- Changes in other revenue sources or resources

Leadership

1. Assist localities build capacity in all disability areas
   - o Address residential capacity issues
     - Funding
     - Zoning
   - o Help localities meet needs for the recovery model
     - Employment services
     - Transportation
     - Medical care
     - Medication for indigent consumers
     - Socialization
   - o Develop consistent outcome measures
   - o Set standards for caseload size
2. Identify and address state-wide issues
   - o Provide centralized bed management
   - o Negotiate with DMAS to determine responsibility for indigent beds
   - o Identify and articulate the State's position on TDOs and the admission criteria for TDO facilities
3. Generate a workforce development plan at the State level
   - o Initiate efforts with community colleges, colleges and universities to train staff
   - o Develop initiatives with institutions of higher learning to attract graduates to the field
     - Establish scholarship opportunities
     - Eliminate disincentives, such as lack of reimbursement for psychiatric services
     - Review QMHP requirements

Communication to Ensure Effectiveness, Efficiency and Mutual Trust

1. Establish regular channels of communication with leaders in the community.
2. Establish and adhere to policies and procedures to ensure timely response to local requests for information and policy interpretation.
3. Ensure consistent communication among internal divisions in the Department.
4. Respond to and act upon recommendations from CSB Executive Directors.

REGION 6 STRATEGIC PLAN – SOUTHERN VIRGINIA

1. Fund additional Discharge Assistance Project (DAP) plans (Danville 14, Piedmont 12, and Southside 7)
2. Expand existing Purchase Inpatient Services fund to reduce CSB admissions to SVMHI by half.
   a. Change focus of SVMHI to serve longer-term patients
   b. Implement the Consortium's Utilization Management Plan.

3. Implement two PACTs to provide PACT services in each of the three participating Consortium CSBs.
4. Expand the existing Regional Consortium as a more formal entity.
    a. Work with the Virginia Tech Institute for Innovative Governance, School of Public and International Affairs to develop a "vision" of long-term goals for the region.
    b. Consider the possibility of establishing a non-profit, legal entity.
    c. Refine the planning process that will involve a more comprehensive representation of stakeholder/providers of services and consumers.

Regional Partnership Recommendations for State-Level Action:

1. Provide funding for DAP, POS and PACT services.

HPR 7 STRATEGIC PLAN – CATAWBA AREA

1. Provide a comprehensive system of appropriate crisis diversion and treatment, both inpatient and outpatient, for adults with mental illness and a co-occurring disorder such as mental retardation or substance abuse, if present.
    a. Expand crisis stabilization capacity.
    b. Develop increased response with intensive supports and case management so crisis clients can avoid hospital admissions.
    c. Purchase of inpatient beds for post commitment patients who are awaiting transfer to Catawba Hospital.
    d. Increase communication and cooperation between CSB Crisis Services programs, RESPOND (L-G) and CONNECT (Carilion).
2. Explore and develop alternative treatments for adults with acquired brain injury in cooperation with the Brain Injury Association of SW Virginia.
    a. Liaison with BIASWV to determine appropriate methodologies and resources for people with Acquired Brain Injury.
    b. Receive education and guidance from BIASWV and health care systems to determine most appropriate care for patients with brain injury requiring structure and control.
3. Ensure access to critical information following appropriate AHIMA/HIPAA regulations within 24 hours of request.
4. Develop an appropriately manned task force to address treatment protocols and critical pathways for common treatment modalities across the region.
    a. Engage University of Virginia Medical Education/Residency.
    b. Identify most appropriate individuals from area institutions and agencies to define common areas of treatment concerns.
    c. Establish clear objectives and timelines for completion of the task with disincentives for noncompliance.

Regional Partnership Recommendations for State-Level Action:

1. Finalize the Pharmacy plan by completion of the Memoranda of Understanding between DMHMRSAS and BRBH.

Catawba Region Child/Adolescent Work Group Report Recommendations

1. Develop additional capacity for traditional front door, outpatient services inclusive of stand alone assessment and intake and as well additional outpatient therapy availability.

2. Further examine the ability to increase psychiatric capacity within the current system of services.
3. Provide support and leadership, in partnership with other core agencies to develop interagency guidelines for transition of youth into adult services.
4. Partner with other child-serving agencies to develop a "road map" for child and family services across the broader service system of core agencies and private providers.
5. Continue to provide support for the successful attainment of the CSA Regional Steering Committee's primary goal: to develop a short-term evaluation and residential facility within the region.

Appendix E
Summary of Special Populations Workgroup Recommendations

CHILD AND ADOLESCENT SPECIAL POPULATIONS WORK GROUP RECOMMENDATIONS

DMHMRSAS should adopt the system of care model developed by the Georgetown University's Technical Assistance Center for Children's Mental Health and adopted by SAMHSA.

DMHMRSAS should lead the statewide promulgation of this system of care model with other state agencies, families, CSBs, and other public and private providers.

Major Funding Priorities

1. Fund four system of care demonstration projects ($2.5 million).
2. Fund Parent/Youth Involvement Network ($500,000 for the first year – $1 million for second year).
3. Fund Behavioral health services provided by CSBs in detention centers during and after detention stay ($3.5 million).
4. Maximize all resources in Virginia to build the capacity for behavioral health services that includes a comprehensive continuum of prevention, early intervention, and intensive therapeutic services.
    a. Increase Medicaid rates for day treatment services to $150 per day.
    b. Add substance abuse services to the DMAS State plan and provide funding for treatment services for youth and their families with primary or secondary substance abuse diagnoses ($5 million).
    c. Conduct a rate study to expand community-based services in the state plan to include:
        i. Intensive Case Management Level System in CSBs
        ii. Parenting Education
        iii. Respite services
        iv. Behavioral Aides.
    d. Fund training priorities, which follow:
        i. Systems of Care ($500,000 for 5 regional and 1 state training);
        ii. Fund slots for university training of child psychiatry fellows and child psychology interns with payback provisions ($60,000 per fellow, $26,000 per intern).
    e. Fund Multisystemic Therapy (MST) and Functional Family Therapy (FFT) capacity building ($2.5 million to include training and statewide licensure, and to oversee and fund local MST/FFT services).

Other System of Care Recommendations

1. Through the DMHMRSAS, recommend to the State Executive Council and the General Assembly possible Code, regulatory changes, and budget initiatives to support the revision and expansion of state and local systems of care.
2. Include prevention and early intervention services for children and their families with or at risk of mental health, mental retardation, and substance abuse problems in the system of care.
3. Work with state agencies to continuously blend and braid funding sources to meet the needs of children and adolescents with MH/MR/SA problems and their families.
4. Support and expand the DMHMRSAS Office of Child and Family Services to assure that children's behavioral health services are prioritized and include all service entities related to children and their families.

Additional recommendations related to increased funding

1. Conduct statewide trainings on evidence-based, best practices, and promising treatments for children with behavioral health problems – statewide workshops, seminars, and cross-community trainings
2. Fund cross-state and agency National Systems of Care model training ($200,000 managed by DMHMRSAS with VACSB)

Recommendations not related to funding

1. Encourage partnerships and collaborations among parents, all providers, and other stakeholders of children and their families with behavioral health problems
2. Support the continuation of the Child and Adolescent Special Population Workgroup activities by merging the membership with the group established by Budget Item 330-F of the 2004 Appropriations Act
3. Support systems of care model including: 1) a coordinated, integrated, and individualized treatment plan; 2) families and surrogate families are full participants in all aspects of the planning and delivery of services; and 3) support a unitary (i.e., cross-agency) care management/coordination approach even though multiple systems are involved, just as care planning structures need to support the development of one care plan.
4. Promote integration of services across MHMRSA disabilities by establishing policies that require services providers to conduct a single comprehensive intake addressing the areas of MHMRSA and developing a unified services plan and record
5. Continue the dissemination of the Commission on Youth's "Collection" of evidence-based practices
6. Seek grant funding to enhance child and adolescent behavioral health services by establishing matching fund capacity through private foundations/corporations
7. Strengthen university/community partnerships to enhance child and adolescent behavioral health services
8. Encourage DMAS to "suspend" rather than "terminate" Medicaid benefits while children and adolescents are in a public institution including state hospitals, juvenile detention centers, juvenile correctional facilities, and jails.

GERIATRIC SPECIAL POPULATIONS WORK GROUP RECOMMENDATIONS

General Recommendations for Improving the System of Geriatric Services

1. Develop a Master Plan for Geriatric Services, outlining a standard continuum of specialized services to meet the complex needs of geriatric patients.
    a. Specify the types, levels, and scope of services to be provided, expected programs and schedules, staffing, and funding requirements.
2. Establish additional community-based services to meet current unmet services needs.
    a. Add geriatric specialists at Community Services Boards.
    b. Create more community-based residential treatment services that could be used as an alternative to more restrictive institutional placements.
    c. Create an office or division within DMHMRSAS to provide more focus and support for this effort.

3. Maintain state hospital geriatric beds.
    a. Continue to test alternatives that may be less costly or more community-based than the state hospital.
    b. Strengthen coordination and planning between state hospital specialists and community providers, including the CSBs, to maximize community placements and enable community providers to access hospital staff expertise.
4. Quantify the increased geriatric services that will be needed at each level in the continuum of services, in response to a rapidly growing geriatric population that will approximately double over the next 25 years.
    a. Continually expand funding, staffing, space, and services structures to handle the growing numbers of geriatric consumers.
5. Conduct extensive reviews of those approaches (model programs) that have been successful in providing effective treatment and quality-of-life to geriatric consumers and their families, so we can capitalize on those approaches in Virginia.
    a. Learn from how other states have structured their geriatric services, as well as from effective approaches used Virginia.
    b. Recognize staff operating effective programs, and information disseminated to promote use of the programs by others.
6. Develop standard data sets and reports that can be used in planning needed services, evaluating services outcomes, and making improvements.
    a. Collect population data to show current and projected geriatric population by various localities.
    b. Collect data on availability of services providers by type and location.
    c. Collect data that reflects the comparative costs and outcomes of various services.
7. Maximize the use of Medicaid and Medicare, and grants in support of needed services.
    a. Look for increased flexibility in making the best use of available funding within federal guidelines.
    b. Test new programs using demonstration grants when feasible.
    c. Encourage DMHMRSAS and DMAS to work collaboratively to identify strategies to remove barriers to funding needed community-based geropsychiatric services.
8. Provide ongoing coordination between the agencies delivering services to geriatric patients.
    a. Conduct joint planning, review of service delivery, collaborative problem solving, and continuing reviews of outcomes of services.
9. Inform and educate consumers and families about available services and entitlements, and how to access them.
    a. Through multi-agency efforts, organize needed information in useable forms and get it into the hands of consumers.
10. Increase supports to family caregivers, to enable them to provide care to geriatric consumers as long as possible, reducing demands on public-provided services**.**
    a. Provide assistance with the costs and daily demands of caregiving to family caregivers so geriatric consumers at home longer
11. Strengthen training and continuing education of caregivers.
    a. Identify where the gaps are in reaching caregivers with necessary training.

b. Make better use of existing training resources to meet the needs.

12. Increase supports to long term care facilities.
    a. Make geropsychiatrists and related mental health professionals available to Nursing Homes and Assisted Living Facilities to help them to manage residents with severe mental illness and dementia.
    b. Provide hands-on training and live supervision on mental health issues
    c. Update old and new staff on how to handle a range of demanding problems and how to adapt their approaches to individual patients.
13. Develop partnerships with primary physicians and work through various agencies to extend continuing education to them, for the purpose of improving detection of mental illness and referral to specialists.
    a. Plan effective continuing education has to be done in partnership with physicians and other professional providers to assure programs match their educational levels and scheduling is realistic given the demands of their practices.
    b. Involve the relevant professional agencies and boards.
14. Develop a specialized focus on geriatric consumers having both mental illness and dementia.
    a. Designate this population as needing the same specialty status and funding for training as other dually diagnosed populations.
    b. Revise Virginia Medicaid criteria to support proper care for elderly persons with severe behavioral problems and to reflect modern understandings of the origins of mental disorders as well as evidence-based treatment practices.

Specific Initiatives for 2004-2005

1. A Beacons Program -- Identify, recognize, and promote examples of model programs (or program components) operating in Virginia.
2. Educational Program for Physicians -- Prepare and educational program in collaboration with appropriate agencies and professional organizations, to reach primary care physicians and geriatric specialists who treat geriatric consumers.
3. Compilation of Training Resources -- Compile training resources by region that can be accessed by providers, consumers, and families.
4. Compilation of Geriatric Services -- Compile a directory of geriatric services that includes descriptive information about available services by region, information on entitlements, and how to access services.
5. Obtain Data for Planning -- Review existing databases that could be useful in planning geriatric services and extract preliminary data for use by the Geriatric Team.

MENTAL RETARDATION SPECIAL POPULATIONS WORK GROUP RECOMMENDATIONS

MR Special Population Workgroup Mission Statement

Rebalance Virginia's service system to become more individually focused where people receive services in the community, based on their individualized needs regardless of funding source. This will be accomplished by building capacity for those persons with all levels of developmental disabilities inclusive of co-occurring conditions, which are funded in a manner that is consistent with the values of self-determination.

Short-Term Recommendations

1. Provide training to increase the expertise of community professionals and paraprofessionals to ensure that service providers have the knowledge, skills, and abilities to address current client needs, evolving complexity of client care, and the decreasing skills of the available workforce for entry-level client care positions.

   Policy –

   a. Extend licensure system to identify providers offering specialty programs and licenses for specialty programs (a tiered license program with specialty certification).
   b. Develop a tiered licensing program with specialty certification.
   c. Link licensure for specialty programs with training requirements to ensure needed staff knowledge, skills and abilities.
   d. Prioritize development/expansion of community and facility services to those with dual diagnosis.

   Administrative –

   a. Create Memos of Agreement, signed by DMHMRSAS Directors' of MR, MH, and SA, to establish leadership for an overarching philosophy of a client needs-based system of treatment, rather than the current disability-based system.
   b. Enhance CSB performance contracts by requiring cross training in assessment and treatment of persons with dual diagnosis.
   c. Identify current best practice training programs for community MR services. Establish a standardized training curriculum for CSB case managers, as well as for private provider residential and vocational staff. Develop other training curriculum as needed.
   d. Support provider participation in training curriculum to assure minimum standards of training for all staff. (e.g., by supporting the direct care professional training through The College of Direct Support from the University of Minnesota program).

   Appropriations –

   a. Support funding for development of a standardized training curriculum.
   b. Support funding for training materials and costs of trainers.
   c. Support supplement funding for community providers so they can obtain reimbursement for direct care staff's pay during required training.
   d. Support funding for development of MR/MI PACT Teams.
   e. Provide incentives for clinical providers to attend training, such as CEU's and tax credits.

   Services –

   a. Expand service options for children/adolescents with MR with strong emphasis on in-home family supports.
   b. Provide cross training of CSB MH, MR and SA staff at all levels. Adopt mandatory performance expectations for direct care/clinical staff in the assessment and treatment of persons with dual diagnosis.
   c. Identify and/or develop regional experts to provide consultation and training to community clinical providers.
   d. Develop regional MR/MI PACT Teams.

2. Develop policies that do not have a negative financial impact on community private providers when clients need temporary out-of-home placements (e.g., hospitalization) or spend time with

family to sustain relationships. Recognize that funding the individual includes, and requires, that the person have stable housing.

Policy –

a. DMHMRSAS to fully support the assertion that residential private providers are providing a essential resource that is vital to community integration of clients, and therefore, capacity to hold the residential placement during temporary out-of-home placements is critical to successful community integration.

Administrative –

a. Direct DMHMRSAS to work with DMAS and other agencies to resolve the discrepancy between the individual's need for stable, continuing housing and current Waiver funding constraints to maintain placements when out-of-home services are needed.

Appropriations –

a. Conduct analysis of costs regarding current duration and reasons for client absences from community placements.
b. Create an equitable mechanism to allow reimbursement of both ICF/MR and MR Waiver programs for consumer absences due to hospitalization and other temporary circumstances in order to maintain a person's home.

3. DMHMRSAS request increased funding for community services each year, specifically related to maintenance of current services (e.g., utilization, inflation, and COLA) and expansion of services.

Policy –

a. Develop DMHMRSAS requests for funding to community services so that adequate levels and capacity of services are maintained and/or developed to meet the needs of persons with MR. In collaboration with appropriate state agencies and regional reinvestment committees, DMHMRSAS budget development should address:
    - Analysis of regional environmental factors (i.e., economy, workforce availability & competition, unemployment and population trends).
    - Identification and analysis of the per capita rate and number of persons who are uninsured in each region.

Administrative –

a. In collaboration with appropriate state agencies and regional reinvestment committees, DMHMRSAS should conduct a formal needs assessment of regional services to persons with MR.

Appropriations –

a. Expand the types of Medicaid Waivers for MR community services. Provide increased funding at levels that will ensure maintenance and stability of current community services as well as necessary expansion.

4. Create a statewide database that matches needed supports of persons with developmental disabilities with qualified providers. This database will be also used for planning future service needs and funding requests.

Policy –

a. Through the DMHMRSAS Office of Mental Retardation, spearhead a system-wide effort to collect and maintain a database that facilitates the match between consumers, service needs, and providers of residential and vocational options.

Administrative –

a. The Database Subcommittee of the MR Special Populations Work Group will develop recommended data elements for the profile needs of providers, consumers and services.
b. DMHMRSAS will develop a statewide database system for this purpose using existing databases where appropriate.

Appropriations –

a. Identify and provide necessary funding for DMHMRSAS staff to develop, implement, and maintain the database.
b. Identify and provide necessary funding to support on-going training and use of the database by the Office of Licensure, Office of Mental Retardation, CSB case management staff, and private providers.

5. Improve overall funding to promote and reward best practice support strategies for all staff in order to increase stability of direct support professionals through:
   - Training, development, and credentialing
   - Tax credits to employers and providers
   - Staff salaries and benefits that reflect regional economic and other environmental factors (e.g., job competition, workforce availability, cultural diversity, etc.)

   Policy –

   a. Establish legislation that ensures the continuation of adequate funding for the community-based system through adoption of public policy that includes an annual cost of living increase for all services.

   Administrative –

   a. Increase collaboration between DMHMRSAS and other State agencies to obtain additional funding from Federal sources (i.e. SAMHSA for dual diagnosis projects).
   b. Develop DMHMRSAS funding requests for community services so that adequate levels and capacity of services are maintained and/or developed to meet the needs of persons with MR.
   c. In collaboration with appropriate state agencies and regional reinvestment committees, address regional factors (i.e., economy, workforce availability & competition, unemployment, cultural diversity, and population trends) in DMHMRSAS budget development.

   Appropriation –

   a. DMHMRSAS will encourage funding of such initiatives with the support of advocacy organizations.
   b. DMHMRSAS should submit a proposal to the General Assembly to provide supplemental funding to community providers for training of direct care staff due to lack of reimbursement for staff pay when a client is not yet residing in the home (i.e., as a part of start-up costs).

   Services –

   a. Support provider participation to assure minimum standards of training for staff (e.g. by supporting the direct care professional training through the College of Direct Care University of Minnesota program).
   b. Expand the types of Medicaid Waivers for MR community services.

SUBSTANCE ABUSE SPECIAL POPULATIONS WORK GROUP RECOMMENDATIONS

Policy Actions

Funding

1. Target Reinvestment funds to support services for the populations with co-occurring MH/SA, both children and adults.
2. Make the expansion of Medicaid coverage for the treatment of substance use disorders a Departmental priority:
    - The Commissioner and other Departmental leadership should influence the Secretary of HHR to require DMAS to include DMHMRSAS in policy development and implementation regarding SA, including the Family Access to Medical Insurance Security (FAMIS) Plan, EPSDT, FAMIS Plus, and general Medicaid funds;
    - The Office of Substance Abuse Services should develop and disseminate a policy paper supporting the use of Medicaid for SUDs; and
    - Provider organizations should demonstrate strong support for key legislators to initiate budget bills for Medicaid expansion.

Improving the Stature of the Office

1. The Department should establish SA specific representation on the System Leadership Council by including the chair of the SA Council of the VACSB, the chair of the Prevention Task Force of the VACSB, the Chair of the SA Services Council and the President of the Virginia Association of Drug and Alcohol Programs (VADAP).
2. OSAS should work to strengthen and develop the burgeoning research partnership between VCU (including MCV), OSAS and the CSBs.
3. The Department should include private sector leadership (VADAP and VADAAC) in systems planning and service delivery execution.
4. The Department, working through the Secretaries of HHR and Public Safety and the Substance Abuse Services Council, should promote closer involvement with the criminal justice system in the development of quality standards for assessment and service delivery.

Data

1. The Department should assure compliance with the requirements of § 37.1-207.
2. The Department should support the development and use of appropriate outcome measures to demonstrate cost offsets of providing treatment and prevention services.

Advocacy

1. The Department should continue to support the development of organized advocacy efforts.
2. The Department should continue to emphasize consumer involvement and empowerment in all aspects of treatment.
3. The Department should encourage and improve advocacy activities that provide educational information about specific issues related to substance use disorders.

Program Actions

Funding

1. The Department should host a “summit” to explore and develop ideas about the use of Medicaid to support treatment for substance use disorders.

2. OSAS should invite DMAS staff to training and other events that would enhance understanding of substance use disorders.
3. The Department should develop a mechanism that supports tracking funds with specific consumers affected by facility diversion.
4. OSAS should continue to provide technical assistance to other state agencies and to community-based programs seeking competitive grant funds.
5. OSAS should continue to compete for grant funds that would support its mission and goals.

Office Stature

1. OSAS, in conjunction with an interagency work group that includes CSBs, private providers and consumers, should develop "best-practice"-based standards for treatment programs supported with public funds that will form the foundation for future regulatory action.

Data

1. OSAS should work closely with the Substance Abuse Services Council in developing its report on and implementing responsibilities related to implementing § 37.1-207.
2. OSAS should develop a "how to" manual to support local program ability to evaluate outcomes.
3. OSAS should develop a *logic model* to support resource allocation and program design.

Advocacy

1. OSAS should continue to provide technical support to SAARA regarding organizational growth and leadership development.
2. OSAS should publish research-based reports that substantiate the cost-effectiveness of substance abuse services.

FORENSICS SPECIAL POPULATIONS WORK GROUP RECOMMENDATIONS

1. Establish the following goals for the provision of community-based mental health services to individuals in the criminal justice system with serious mental illness:
   a. Minimize the number of non-violent individuals with mental illness or serious substance abuse disorders in the criminal justice system
   b. Enhance the delivery of mental health services to incarcerated individuals, both to reduce demand for hospitalization and to prevent re-hospitalization of individuals returned to incarceration following inpatient treatment & evaluation
   c. Provide access to hospital care, when appropriate, with minimum delays, so that the resulting length of hospitalization may be reduced, and the management of mentally ill individuals in the jail may be enhanced.
   d. Require appropriate cross-training for key players in both the mental health and criminal justice services communities.
   e. Provide adequate resources to localities, so that required systems changes can be implemented.
2. Continue to respond to the mandates of SJR 81, of the 2004 General Assembly, and related budget language requiring the DMHMRSAS to develop a web-based program for the sharing of innovative practices for the treatment of individuals with mental illness and substance abuse treatment needs, and to continue the activities of this work group. (Although the DMHMRSAS has recently implemented a web-based program of this type, additional follow-through work is needed in this area.)

3. Devote additional study and analysis to the issue of substance abuse among the offender population. Substance abuse constitutes a key or overriding problem faced by all of the populations targeted by the work group agenda.

4 Support implementation of the plan of recommended actions that has been submitted by the Juvenile Justice Subcommittee of the Child and Adolescent Special Populations Work Group.

5. Through budgetary language and funding initiatives with the Virginia General Assembly, complete the following actions:

   a. Develop a model Community Policing curriculum for Crisis Intervention Training for law enforcement officers in all jurisdictions of the Commonwealth.

   b. Support in language and with resources the improved access of the courts in Virginia to the services of expert mental health evaluators.

   c. Direct the implementation of, and provide sufficient resources to develop a statewide cross-training program, developed through the DCJS, in all relevant areas of mental health and substance abuse assessment and treatment, geared toward law enforcement, jail personnel, court personnel, and mental health personnel having involvement with service delivery in the criminal justice system.

   d. Direct the development of, and provide resources for implementing a joint VACSB/DMHMRSAS/law enforcement information sharing system.

   e. Endorse and direct the provision of renewable resources for the continuation of those model Virginia programs that are currently funded by temporary federal grants, or do not have a specified funding stream, such as the Montgomery County Crisis Intervention (CIT) program, the Chesterfield Day Reporting Center, and the Norfolk Mental Health Court.

   f. Direct the DMHMRSAS and the Virginia CSBs to implement the community-based Restoration to Competency To Stand Trial program that has recently been developed on a statewide basis. Provide sufficient funding and other needed resources for each CSB to accomplish this goal.

   g. Provide resources and budget language to develop pilot jail MH and SA services programs, based upon evidence-based approaches, for at least 3 Virginia jails.

   h. Using a pilot program approach, provide resources and directives necessary for the development of additional mental health courts in the Commonwealth.

   i. Provide resources necessary to develop the means for the Department of Corrections, the DCJS, the Virginia Board of Compensation, and local and regional jails, in conjunction with the DMHMRSAS, to accurately depict the current population of inmates having serious medical illnesses, mental illness and substance abuse disorders in local, regional and state correctional facilities, and under the supervision of DOC Community Corrections and local offices of probation and parole.

   j. Allocate sufficient resources and provide directives to develop a statewide, multi-agency approach toward planning and providing a model pharmacy and drug formulary program that will ensure the use of “best practices” in selecting the range and types of medication to be used by medical providers in the jails and prisons of the Commonwealth.

   k. Provide for the allocation of DMHMRSAS resources for the maintenance and upgrading of the Forensic Information Management System (FIMS).

   l. Provide language and resources to ensure that there is an adequately trained group of forensic mental health evaluators available throughout the state to conduct court-ordered evaluations on an outpatient basis.

m. Direct and denote resources for the implementation by the DMHMRSAS of a comprehensive program for training mental health and criminal justice professionals and others in evidence-based, “best practices” approaches to the provision of community-based and facility-based mental health and substance abuse treatment modalities for individuals with criminal justice system involvement.

6. Change Virginia Medicaid regulations in the following ways: Provide for “suspension”, rather than “termination” of Medicaid benefits to recipients who are incarcerated in local and regional jails. Alter Virginia Medicaid regulations to provide for reimbursement to providers of Substance Abuse treatment services to Medicaid recipients.

7. Endorse the concept of designation of community psychiatric facilities as proper treatment sites for nonviolent criminal defendants in need of acute care.

8. Promote the successful adoption of the recommended changes requested of the Office of the Executive Secretary of the Supreme Court of Virginia (OESSCV) by DMHMRSAS Commissioner Reinhard, regarding forensic evaluations services, in his letter of July 6, 2004 to Secretary Baldwin.

9. Continue to develop procedures for DMHMRSAS psychiatric hospitals to complete outpatient evaluations for the courts, and continue to work with the criminal courts to divert evaluations to community providers, wherever appropriate.

10. Encourage the review and appropriate modification of DMHMRSAS inpatient programs for individuals found “Not Guilty by Reason of Insanity (NGRI)” or “Unrestorably Incompetent to Stand Trial (URIST)”, as well as “mandatory parolees”.

11. Consult with the Virginia Board of Corrections regarding the need to expand upon the current mental health standards set by that body for local and regional jails, in *Virginia Administrative Code* § 6VAC15-40-1010.

12. Integrate the activities of the Governor’s NGA Policy Team for Prisoner Reentry with this work group process, as feasible.

13. Continue to identify and recommend all necessary changes in these areas that shall be required to implement each programmatic goal of the work group: Funding/resource allocation needs; local/state policy changes; memoranda of agreement for designated activities; changes in the *Code of Virginia,* or *Virginia Administrative Code*; licensure/certification procedures needed; human rights procedural guarantees.

Appendix F

Potential Models for Aligning Acuity and Complexity and Level of Functioning to Services and Supports Interventions

Consumer Focused Service System:
A Model for Intensive Mental Health Services

Developed by the Northern Virginia Regional Strategic Planning Partnership

Levels of Inpatient Needs and Services

The following four models of psychiatric inpatient care are intended to describe various levels of services required by people receiving inpatient psychiatric services. These four models are organized along the dimensions of acuity and complexity of mental health concerns of treatment recipients.

> **Acuity** is a measure of immediate clinical status. High acuity may be characterized by current suicidal preoccupation; physically aggressive outbursts; serious verbal threats; high level of verbal and/or physical agitation; presence of disordered thinking; impairment in judgment; and/or confusion. Patients with high acuity may have an increased need for psychiatric monitoring, medical monitoring, and assistance with self-care, and may be less likely to actively participate in treatment.
>
> **Complexity** is a measure of symptoms and experiences of individuals receiving psychiatric services, which can be more persistent over time. High complexity may be characterized by a history suggesting high suicide risk; danger to others; symptoms that significantly interfere with daily life, including self-care; substance abuse; medical complications; instability or absence of social support; instability of work history; residential instability; difficulty engaging in treatment; medication non-adherence; limited knowledge of illness; and limited or no family involvement.

These models of psychiatric inpatient care include specific levels of service definitions that have been developed for the following population groups:

> **Adults**
>
> **Older Adults**
>
> **Children and Adolescents**

These levels of service definitions incorporate needs indicators, interventions, and expected outcomes:

> **Needs indicators** describe symptoms and experiences often encountered at each level of care.
>
> **Interventions** illustrate typical services required by service recipients at the various levels.
>
> **Expected Outcomes** describe treatment goals commonly identified at each level of service.

Level of Service Definitions for Adults:

LEVEL I: Acute Stabilization for Adults		
Need Indicator	Interventions	Expected Outcomes
High Acuity Low Complexity • Substance-induced symptomatology • Situational crises resulting from psychosocial stressors • Situational difficulties resulting from Axis II symptomatology • Not taking prescribed medication or in need of medication adjustment (with history of good response to medication	Acute Stabilization requires a multidisciplinary treatment model and a higher staff to patient ratio than intermediate care or rehabilitation services. Interventions are focused around resolution of psychiatric crisis and rapid return to the community. Although they will vary depending upon the individual and the nature of the presenting problem, interventions typically involve: • Increased level of observation • Highly structured treatment milieu • Risk assessment • Frequent, ongoing clinical assessment • Patient and family education and involvement • Cultural/interpretive services • Acute crisis counseling • Detoxification management • Medication stabilization • Medication education • Potential need for physical interventions to manage self-injurious or aggressive behaviors • Medical management, including potential for emergency medication • Immediate, aggressive discharge planning	• Short length of stay (2-5 days) • Rapid stabilization of symptoms • Resolution of risk/safety issues • Effective continuity of care plan • Linkages with substance abuse services • Timely communication and appointments with community providers

LEVEL II: Intensive Care for Adults		
Need Indicator	Interventions	Expected Outcomes
High Complexity High Acuity • Unsafe behaviors requiring intervention • Current lack of willingness or ability to participate in treatment	Intensive Care necessitates an interdisciplinary treatment model to fully address complexity of presenting problems, and interventions require a higher staff to patient ratio than intermediate care or rehabilitation services. Interventions are focused around resolution of more long-term, persistent or recurrent psychiatric difficulties and return to the community with the expectation of improved community tenure. Treatment may be characterized by: • Possible increased level of observation • Structured treatment milieu • On-going risk assessment • Frequent, ongoing clinical assessment • Legal authorization of treatment • Flexible assessment and treatment approaches • Highly individualized services • Modalities which encourage motivation and engagement in treatment • Patient and family education and involvement • Cultural/interpretive services • Group and individual treatment modalities • Behavioral assessment and intervention services • Primary care services to address medical co-morbidity • Stabilization and on-going management of medical issues • Medication education • Medication management • Potential need for physical intervention • Potential need for emergency medication • Individualized, creative, and flexible discharge planning • Supported transition to community services	• Length of stay 30 days or less • Stabilization of symptoms • Resolution of risk issues • Effective continuity of care plan • Highly individualized discharge plan, including co-morbidity issues addressed • Linkages with community substance abuse services • Linkages with primary care service in community • Timely communication/ appointments with community providers • Beginning readiness to explore relapse prevention and recovery

LEVEL III: Intermediate Care for Adults		
Need Indicator	Interventions	Expected Outcomes
High Complexity Variable Acuity • Residential instability • Sustained imminence of risk to self or others • Challenging behaviors with complex etiologies • Inconsistent self-management of symptoms or need for changes in relapse prevention plan	Intermediate Care requires an interdisciplinary treatment model to address complexity found at this level of care. Staffing levels that are lower than acute or intensive care levels of care, but which have flexibility to address variable acuity, are required for this level of care. Treatment is focused on resolution of identified barriers to recovery and identification of placement and services supportive of a successful transition to, and tenure in, the community. Interventions may include: • Variable levels of observation • Structured treatment milieu • On-going risk assessment • Possible legal authorization of treatment • Modalities which encourage motivation and engagement in treatment • Individual psychotherapy • Patient and family involvement and education • Cultural and interpretive services • Psychosocial rehabilitation programming • Vocational rehabilitation services • Skill building • Behavioral assessment and intervention services • Substance abuse programming, services, and referrals • Forensic services • Co-morbidity/ primary care services • Complex medication management • Potential need for physical intervention • Potential for emergency medication • Extensive residential planning • Creative discharge planning, including consideration of step down or wrap around services • Supported transition to community services • Individualized Integration of recovery-informed Interventions	• Length of stay greater than 30 days • Stabilization of symptoms to support recovery and relapse prevention • Attainment of functional skills required for goal achievement and recovery • Progression through NGRI privileging process • Linkages with outpatient substance abuse and primary care services • Successful transition to community-based living situation

LEVEL IV: Rehabilitation Services for Adults		
Need Indicator	Interventions	Expected Outcomes
High Complexity Low Acuity • Active co-morbid medical complications • Lack of confidence in ability to recover • Lack of clarity around recovery goals	Rehabilitation Services involves a multi-disciplinary treatment model with a lower staff to patient ratio and more independent involvement in treatment and recovery. Focus of treatment is on solidification of adaptive skills, independent management of chronic symptomatology, and development of community supports and a network of services to support enduring success following discharge. Interventions at this level of care typically include: • Motivational/engagement modalities • Integration of recovery-informed interventions • Patient and family education and involvement • Individual psychotherapy • Cultural/Interpretive services • Psychosocial rehabilitation programming • Vocational rehabilitation services • Transportation skill building/services • Forensic services • Substance abuse programming/referrals • Emphasis on independent medication management (vs. medication education) • Medical illness management/primary care services • Discharge planning • Extensive residential planning • Community reintegration • Supportive transition services	• Length of stay greater than 30 days • Maintenance of symptoms at baseline • Acquisition of adaptive skills and improvements in adaptive functioning • Identification and clarification of recovery goals • Increased self confidence and hope • Progression through NGRI privileging process • Maintenance of medical/physical health • Successful transition to residential placement

	Level I High Acuity Low Complexity	Level II High Acuity High Complexity	Level III Variable Acuity High Complexity	Level IV Low Acuity High Complexity
Private Hospitals Acute Stabilization TDO Commitment	✔	(May provide but not publicly funded)	(May provide but not publicly funded)	
NVMHI Intensive Care Intermediate Care Forensics (NGRI) Rehab		✔	✔	✔ (For NGRI only, if no community option available)
Community Acute Stabilization Rehab	✔			✔

Level of Service Definitions for Older Adults

LEVEL I: Acute Stabilization/LEVEL 2: Intensive Care for Older Adults		
Need Indicator	Interventions	Expected Outcomes
High Acuity High Complexity • Substance-induced symptomatology • Situational crises resulting from psychosocial stressors • Situational difficulties resulting from Axis II symptomatology • Not taking prescribed medication or in need of medication adjustment (with history of good response to medication • Unsafe behaviors requiring intervention • Current lack of willingness or ability to participate in treatment • First episode of acute psychiatric illness with Axis I diagnosis or psychotic symptoms and aggressive behaviors induced by a neurological/medical condition requiring psychotropic medication and behavioral interventions to stabilize. Typically presented in an older patient.	Acute Stabilization requires a multidisciplinary treatment model and a higher staff to patient ratio than intermediate care or rehabilitation services. Interventions are focused around resolution of psychiatric crisis and rapid return to the community. Interventions are focused around resolution of psychiatric crisis, assessment of clients' psychiatric as well as neurological and medication conditions, stabilization of dangerous and aggressive behaviors and return to the community or transfer or discharge to a lower level of care. Although they will vary depending upon the individual and the nature of the presenting problem, interventions typically involve: • Increased level of observation • Highly structured treatment milieu • Risk assessment • Frequent, ongoing clinical assessment • Patient and family education and involvement • Cultural/interpretive services • Acute crisis counseling • Detoxification management • Medication stabilization • Medication education • Potential need for physical interventions to manage self-injurious or aggressive behaviors • Medical management, including potential for emergency medication • Immediate, aggressive discharge planning • Consultation and collaboration with other specialists, including but not limited to, neurologists and internal medicine specialists	• 2-3 weeks rapid stabilization of symptoms • Resolution of risk/safety issues • Effective continuity of care plan • Linkages with substance abuse services • Timely communication and appointments with community providers • Discharge plan considers all safety and functioning level needs of client

LEVEL II: Intensive Care (Combine with Level I) for Older Adults		
Need Indicator	Interventions	Expected Outcomes
High Complexity High Acuity • Unsafe behaviors requiring intervention • Current lack of willingness or ability to participate in treatment	Intensive Care necessitates an interdisciplinary treatment model to fully address complexity of presenting problems, and interventions require a higher staff to patient ratio than intermediate care or rehabilitation services. Interventions are focused around resolution of more long-term, persistent or recurrent psychiatric difficulties and return to the community with the expectation of improved community tenure. Treatment may be characterized by: • Possible increased level of observation • Structured treatment milieu • On-going risk assessment • Frequent, ongoing clinical assessment • Legal authorization of treatment • Flexible assessment and treatment approaches • Highly individualized services • Modalities which encourage motivation and engagement in treatment • Patient and family education and involvement • Cultural/interpretive services • Group and individual treatment modalities • Behavioral assessment and intervention services • Primary care services to address medical co-morbidity • Stabilization and on-going management of medical issues • Medication education • Medication management • Potential need for physical intervention • Potential need for emergency medication • Individualized, creative, and flexible discharge planning • Supported transition to community services	• Length of stay 30 days or less • Stabilization of symptoms • Resolution of risk issues • Effective continuity of care plan • Highly individualized discharge plan, including co-morbidity issues addressed • Linkages with community substance abuse services • Linkages with primary care service in community • Timely communication/ appointments with community providers • Beginning readiness to explore relapse prevention and recovery

LEVEL III: Intermediate Care for Older Adults		
Need Indicator	Interventions	Expected Outcomes
High Complexity Variable Acuity • Residential instability • Sustained imminence of risk to self or others • Challenging behaviors with complex etiologies • Inconsistent self-management of symptoms or need for changes in relapse prevention plan	Intermediate Care requires an interdisciplinary treatment model to address complexity found at this level of care. Staffing levels that are lower than acute or intensive care levels of care, but which have flexibility to address variable acuity, are required for this level of care. Treatment is focused on resolution of identified barriers to recovery and identification of placement and services supportive of a successful transition to, and tenure in, the community. Interventions may include: • Variable levels of observation • Structured treatment milieu • On-going risk assessment • Possible legal authorization of treatment • Modalities which encourage motivation and engagement in treatment • Individual psychotherapy • Patient and family involvement and education • Cultural and interpretive services • Psychosocial rehabilitation programming • Vocational rehabilitation services • Skill building • Behavioral assessment and intervention services • Substance abuse programming, services, and referrals • Forensic services • Co-morbidity/ primary care services • Complex medication management • Potential need for physical intervention • Potential for emergency medication • Extensive residential planning • Creative discharge planning, including consideration of step down or wrap around services • Supported transition to community services • Individualized Integration of recovery-informed Interventions	• Length of stay greater than 30 days • Stabilization of symptoms to support recovery and relapse prevention • Attainment of functional skills required for goal achievement and recovery • Progression through NGRI privileging process • Linkages with outpatient substance abuse and primary care services • Successful transition to community-based living situation

LEVEL IV: Rehabilitation Services for Older Adults		
Need Indicator	Interventions	Expected Outcomes
High Complexity Low Acuity • Active co-morbid medical complications • Lack of confidence in ability to recover • Lack of clarity around recovery goals • Continued and unstable episodes of aggression to self or others preventing discharge to a nursing home. ALF, or community	Rehabilitation Services involves a multi-disciplinary treatment model with a lower staff to patient ratio and more independent involvement in treatment and recovery. Focus of treatment is on solidification of adaptive skills, independent management of chronic symptomatology, and development of community supports and a network of services to support enduring success following discharge. Interventions at this level of care typically include: • Motivational/engagement modalities • Integration of recovery-informed interventions • Patient and family education and involvement • Individual psychotherapy • Cultural/Interpretive services • Psychosocial rehabilitation programming • Vocational rehabilitation services • Transportation skill building/services • Forensic services • Substance abuse programming/referrals • Emphasis on independent medication management (vs. medication education) • Medical illness management/primary care services • Discharge planning • Extensive residential planning • Community reintegration • Supportive transition services • Provision of personal care	• Length of stay greater than 30 days • Maintenance of symptoms at baseline • Acquisition of adaptive skills and improvements in adaptive functioning • Identification and clarification of recovery goals • Increased self confidence and hope • Progression through NGRI privileging process • Maintenance of medical/physical health • Successful transition to residential placement • Some may require permanent placement in a state run psychiatrically oriented long-term care facility much like the current ESH Geriatric Program

Level of Service Definitions for Children and Adolescents:

LEVEL I: Acute Stabilization for Children and Adolescents		
Need Indicator	Interventions	Expected Outcomes
• Substance-induced symptomatology • Situational crisis resulting from psychosocial stressors • Situational difficulties resulting from Axis II symptomatology • Not taking prescribed medication or in need of medication adjustment (with history of good response to medication)	Acute Stabilization requires a multidisciplinary treatment model and a higher staff to patient ratio than intermediate care or rehabilitation services. Interventions are focused around resolution of psychiatric crisis and rapid return to the community. Although they will vary depending upon the individual and the nature of the presenting problem, interventions typically involve: • Possible increased level of observation • Structured treatment milieu • Risk assessment • Legal authorization for treatment • Frequent, ongoing clinical assessment • Forensic services • Patient and family education and involvement • Cultural/interpretive services • Acute crisis counseling • Detoxification management • Medication stabilization • Medication education • Potential need for physical interventions to manage self-injurious or aggressive behaviors • Medical management, including potential for emergency medication • Immediate, aggressive discharge planning	• Short length of stay (2-5 days) • Rapid stabilization of symptoms • Resolution of risk/safety issues • Effective continuity of care plan • Linkages with substance abuse services and other primary core services in the community • Timely communication and appointments with community providers

LEVEL II: Intensive Care for Children and Adolescents		
Need Indicator	Interventions	Expected Outcomes
• Unsafe behaviors requiring intervention • Current lack of willingness or ability to participate in treatment	Intensive Care necessitates an interdisciplinary treatment model to fully address complexity of presenting problems, and interventions require a higher staff to patient ratio than intermediate care or rehabilitation services. Interventions are focused around resolution of more long-term, persistent, or recurrent psychiatric difficulties and return to the community with the expectation of improved community tenure. Treatment may be characterized by: • Possible increased level of observation • Highly structured treatment milieu • On-going risk assessment • Frequent, ongoing clinical assessment • Legal authorization for treatment • Flexible assessment and treatment approaches • Highly individualized services • Modalities which encourage motivation and engagement in treatment • Patient and family education and involvement • Cultural/Interpretive services • Individual, family, and group treatment modalities • Acute crisis counseling • Detox management • Educational services • Behavioral assessment and intervention services • Primary care services to address medical co-morbidity • Stabilization and on-going management of medical issues • Medication stabilization • Medication management including potential need for emergency medication • Potential need for physical intervention to manage self-injury/aggressive behavior • Forensic services • Individualized, creative and flexible discharge planning • Supported transition to community services	• Length of stay 30 days or less • Stabilization of symptoms • Resolution of risk issues • Effective continuity of care plan • Highly individualized discharge plan, including co-morbidity issues addressed • Linkages with community substance abuse services • Linkages with primary care service in the community • Timely communication/ appointments with community providers • Beginning readiness to explore relapse prevention and recovery

LEVEL III: Intermediate Care/Long Term Hospitalization for Children and Adolescents		
Need Indicator	Interventions	Expected Outcomes
• Residential instability • Sustained imminence of risk to self or others • Challenging behaviors with complex etiologies • Inconsistent self-management of symptoms or need for changes in relapse prevention plan	Intermediate Care requires an interdisciplinary treatment team model to address complexity found at this level of care. Staffing levels that are lower than acute or intensive levels of care, but which have flexibility to address variable acuity, are required for this level of care. Treatment is focused on resolution of identified barriers to recovery and identification of placement and services supportive of a successful transition to, and tenure in, the community. Interventions may include: • Variable levels of observation • Structured treatment milieu • On-going risk assessment • Legal authorization of treatment • Modalities which encourage motivation and engagement in treatment • Individual, family, and group treatment modalities • Patient and family involvement and education • Cultural and interpretive services • Psychosocial rehabilitation programming • Vocational rehabilitation services • Skill building • Behavioral assessment and intervention services • Substance abuse programming, services, and referrals • Forensic services • Co-morbidity/primary care services • Complex medication management • Potential need for physical intervention • Potential for emergency medication • Extensive residential planning • Creative discharge planning, including consideration of step down or wrap around services • Supported transition to community services • Individual and family integration around recovery principles	• Length of stay greater than 30 days • Stabilization of symptoms to support recovery and relapse prevention • Attainment of functional skills required for goal achievement and recovery • Progression through NGRI privileging process • Linkages with outpatient substance abuse and primary care services • Successful transition to community

LEVEL IV: Residential Services for Children and Adolescents		
Need Indicator	Interventions	Expected Outcomes
• Active co-morbid psychiatric and environmental complications • Lack of confidence in ability to recover with family support needed • Lack of clarity around recovery goals	Residential Services consist of long-term structured settings where the youth is place outside his or her residence. Interventions are provided by a multi-disciplinary treatment team with the goal of learning and incorporating adaptive functioning skills, independent management of chronic symptomatology, and development of family and community supports through a network of wraparound supports to ensure ongoing success following completion of the program. Interventions at this level of care typically include: • Motivational/engagement modalities • Integration of recovery-informed interventions • Patient and family education and involvement • Individual, family, and group treatment modalities • Educational services • Psychosocial rehabilitation programming • Transportation skill building/services • Forensic services • Substance abuse programming/referrals • Emphasis on independent/family member medication management and support • Medical illness management/primary care services • Discharge planning • Discharge and step down service planning • Community reintegration • Supportive transition services	• Length of stay greater than 30 days • Maintenance of symptoms at baseline • Acquisition of adaptive skills and improvements in adaptive functioning • Identification and clarification of recovery goals • Increased self confidence and hope • Academic achievement • Maintenance of medical/physical health • Successful transition to residential placement

	Level I Acute	Level II Intensive	Level III Intermediate-Long-Term Hospitalization	Level IV Residential
Private Hospitals Acute Stabilization TDO Commitment	✔	**	**	
CCCA Acute Stabilization TDO Commitment Intensive Care Intermediate Care Forensics (10 day evaluations)	✔	✔	✔	
Community Acute Stabilization Rehab	✔			✔

**May provide but not publicly funded. May be funded through private pay, CSA.)

Mental Retardation Special Populations Work Group
Matrix of Levels of Need and Support Options

The following matrix depicts services and supports options that would provide appropriate care for individuals who meet the level of care criteria established by Medicaid for ICF/MR eligibility. The x's in the following matrix indicate the services options that most people with certain levels of support needs would likely choose if these options were available. For individuals who meet ICF/MR criteria, all of the matrix options would be available, with the exception that the Training Centers (in this model called Intensive Support Centers; ISC) would be limited to serving only persons with Level 4 and 5 needs. Others who choose an ICF/MR level of care would be served in an Intensive Support Home (ISH) operated by the Commonwealth or a private, community based ICF/MR.

	LEVEL 1	Level 2	Level 3	Level 4	Level 5
OPTION A Enhanced and Improved Community Waiver and Individual and Family Supports	X	X	X	X	X
OPTION B Community Living Options, including ICF/MR, with Day Supports and Other Community Options		X	X	X	X
OPTION C Intensive Support Home (ISH) with Community Options as Appropriate			X	X	X
OPTION D Intensive Support Center (ISC)			Upon request/ discussion	X	X
Available to all Persons with MR Regional Community Support Center	X	X	X	X	X

Levels of Support Needs

The following identified levels of support needs all meet the criteria of care established by Medicaid using the seven categories from the Virginia Level of Functioning assessment tool:

1. Health Status
2. Communication
3. Task Learning Skills
4. Personal/Self Care
5. Mobility
6. Behavior
7. Community Living Skills

Level 1 – Requires some basic supports that are not 24-hour in nature. Respite care may be all that is needed or some skill training for more independent living. "Drop – in" services may be appropriate, or a basic level of supported employment services.

Examples of individuals with Level 1 support needs are:

1. *An individual living at home who's basic support needs are met through regular periods of respite care.*
2. *An individual living at home or in an apartment who's basic support needs are met through in-home residential supports aimed at certain skill development or maintenance issues for independent living.*
3. *An individual living at home who's basic support needs are met through regular intensity day support or supported employment services.*

Level 2 – Some combination of in-home supports and a day support option could meet most needs. Some training or assistance to maintain activities of daily living could be indicated. Support needs could also be met through personal care services. Others at this level could have medical needs met through a limited level of home-based skilled nursing. Could require access to twenty-four hour general supervision.

Examples of individuals with Level 2 support needs are:

1. *An individual who needs basic supports and in-home services to provide training or assistance with some self-care. This might include assistance during the day through services provided in school systems or formal day support to maintain safety and enhance skills of independent living.*
2. *An individual living in a group home with a service plan that addresses some ADL needs through monitoring as well as independent living skill needs through training. Day supports or supported employment would also most likely be indicated. Overnight staff would not necessarily be required to be awake, but available if needed.*

Level 3 – Requires 24-hour supervision. Individuals at this level are typically involved with more complex issues of need such as behavioral interventions, medical monitoring, or skill training/ maintenance in basic activities of daily living.

Examples of individuals with Level 3 support needs are:

1. *An individual living in a natural home who requires moderate levels of supervision most of the time to maintain safety. Training and assistance supports are needed for ADLs, behavioral issues, medical monitoring, or a combination. Day supports or school involvement combined with an in-home service to train and/or maintain skills would be needed. Could have a behavioral or other therapeutic intervention plan.*
2. *An individual living in a group home who requires awake, overnight supervision to maintain safety in conjunction with formal day activities that involves training or supervision.*

Level 4 – Requires 24-hour supervision, much of which is intensive in nature. At times, some level of one-on-one supervision or therapeutic intervention is necessary to protect self, others, or to maintain minimum acceptable standard of life quality.

Examples of individuals with Level 4 support needs are:

1. *An individual who has a history of frequently wandering away from the home or other environment where supports are present into areas that can present hazards to personal safety. This individual may possess poor social skills that can place him/her at risk if supports are not in place.*
2. *An individual whose medical treatment requires close monitoring by a trained professional so as to maintain his/her safety. Monitoring may be by non-professional staff in direct*

support with access to trained medical professionals for review and drop-in visits as needed.

3. *An individual whose behavior is prone to escalate to outbursts that endanger self or others under certain conditions. Maintenance of safety is dependent on support levels being provided by persons trained in the specifics of the behavior plan written for the individual.*

Level 5 – Requires 24-hour medical (to include skilled nursing), behavioral, or other specialized supervision to maintain minimum acceptable standard of quality of life. A high level of training is required for the staff involved in the supports. Individual must have 24-hour access to professionals in medical or other specialty area

SERVICE OPTIONS:

The focus of services and supports must be based on the preferences and needs of the individual. The plans should evolve to support individual choice and foster the provision of adequate resources so individuals can live a meaningful and fulfilled life in the community of their choice. The community supports system must continue to be strengthened through appropriate increases in the rates paid for services, the number and variety of waivers, and through development of a strong system of family supports services and reimbursement that offers real choice for Virginians with mental retardation. A combination of waiver services and family supports has proven to be successful in reducing the reliance on state operated facilities while increasing the success of reaching objectives of self-determination and greater independence for individuals and families. Each region of the state will have the capacity to provide skilled nursing level of supports through public and private partnerships.

Option A: Enhanced and Improved Community Waiver and Family Supports

Option B: Community Living Options, including ICF/MR, along with Day Supports and Other Community Options

Option C: Intensive Support Home (ISH) along with community options as appropriate. The State training centers, CSBs, or private providers would directly operate small, up to 6 bed, community homes (*Intensive Support Home or ISH*) some of which will be in close proximity to the Intensive Support Center). These may be homes that are leased or purchased in the community or new construction.

Option D: Intensive Support Center (ISC). Persons receiving supports and whose home is the *Intensive Support Center or ISC* (now called a state training center) would be required to meet the Level 4 or 5 support needs, or choose this as a living option (their home).

Regional Community Support Center: Regional Community Support Centers will be developed to operate in conjunction with the Intensive Support Centers and medical schools. They will be open for persons from the community to receive services, such as dental, behavioral, nutritional, OT, PT, Speech, or other clinical specialties. They will also be able to have satellite clinics set up around the region on certain days for specific services.

Access to the Intensive Support Centers (ISC) and Intensive Support Homes (ISH) must be made available to all qualifying persons at the time of need.

Access will be determined through a special committee made up of regional representatives involving both the community services board serving the area, ISC/ISH representative, family, and consumer.

Prior to admission for those persons seeking temporary treatment, the approximate length of stay will be determined and an appropriate discharge plan will be developed